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ABSTRACT

These abstracts of conference presentations are intended to serve as a record and reference of current clinical practice, program planning, and research ideas and results in the field of occupational therapy. Abstracts are grouped in the following categories: (1) preconference institutes; (2) general interest; (3) administration/management; (4) education; (5) gerontology; (6) mental health; (7) pediatrics; (8) physical disabilities; and (9) assistive technology labs. Samples of presentation topics include developing handwriting and manipulation skills in children, strategies for bridging children's cultural worlds, occupational therapy practice and education in Mexico, play of African-American and Nigerian preschool children, an ecological model of school-based occupational therapy, a videotape protocol for assessing pervasive multiple impairments, teaching critical thinking in orthotic education, strategies for better instruction in occupational therapy, an innovative approach to teaching assistive technology, and interactive multimedia computer-assisted instruction. (DB)

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The American Occupational Therapy Association's
1995 Annual Conference and Exposition
Saturday, April 8 – Wednesday, April 12, 1995
Colorado Convention Center • Denver, Colorado

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Conference Abstracts and Resources 1995

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FOREWORD

Diversity: Our Journey Together, the theme for the American Occupational Therapy Association (AOTA) 1995 Annual Conference, provides a venue to explore and focus on issues dealing with diversity as it pertains to education, practice, and our own individual actions. Conference programs focus on addressing the need for awareness, sensitivity, and inclusion of the entire human community within the realm of occupational therapy. The future of the profession is facing many challenges. None at times seems as daunting as the human factor. In a society that is experiencing vast economic, social, and demographic changes, awareness of and education about the many cultures, racial and ethnic origins, religious beliefs, and sexual orientation are essential.

Conference Abstracts and Resources 1995 is a publication of abstracts from programs during the AOTA 1995 Annual Conference. This publication is intended to serve the occupational therapy professional community and others as a record and reference of current clinical practice, program planning, and research ideas and results presented at the annual conference. It is our hope that this publication will be valuable to practitioners, educators, scholars, and students, whether they attend the conference or not. To allow researchers access to materials presented at the annual conference, the abstracts published here are also indexed in OTBibSys, the bibliographical database of the Reliable SOURCE.

AOTA extends its thanks to all contributors to *Conference Abstracts and Resources 1995*. Presenters were asked to voluntarily prepare and submit abstracts for their program session. It is their willingness to share information that has advanced the profession of occupational therapy.

AOTA would like to continue its efforts to produce substantive publications that meet the needs of the occupational therapy profession and all AOTA members. We welcome your comments and suggestions.

Elizabeth Holcomb
Acquisitions Editor

Fran McCarrey
Director, Nonperiodical Publications

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PRECONFERENCE INSTITUTES

Title

OCCUPATIONAL THERAPY CONSULTATION:
ADDRESSING DIVERSITY IN PRACTICE

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Key Words

Consultation models, diverse practice settings, human ecological perspective

Abstract

Changes in society and health care delivery mandate a broadened base of practice for the occupational therapist. Occupational therapy consultation will become an increasingly important component of practice as we move to a comprehensive view of society that addresses the increased diversity in patient/client population and life styles. Utilizing a consultation model based on a human ecological approach, therapists can develop strategies to enhance their practice by addressing the impact of a changing environment. Adaptive techniques using a holistic view of the environment; increased communication skills, information, knowledge of resources; and expertise in ecological consultation is essential to a rapidly changing practice.[3]

Demands for occupational therapy consultation services have expanded with explosion of new technologies, increased health legislation, cultural diversity, demographic shifts, and rapid changes in our economy and health care needs. Recent legislation,

including the Services for Pre-School Age Children (PL99-457), Supportive Technology for the Disabled (PL100-407), and the Americans with Disabilities Act (PL-101-336) (ADA), have increased the demand for skilled occupational therapy consultants. Enhancement of consultative skills to help consumers, families, employers, and communities assess needs, identify strengths, and develop resources is essential.

By the year 2000, occupational therapists will be engaged in practice systems which require consultation involving a wide range of economic, demographic, cultural, and ethnic variables.[3] Expanded community and workplace health and wellness programs and a variety of health and human service programs provide occupational therapists with opportunities and increased challenges as the diversity in practice increases. Therapists will be involved in broadened political lobbying for health care legislation, consumer advocacy activities, and regulatory and reimbursement areas. ADA legislation will create increasingly expanded needs for consultation to businesses and communities. [1, 3] Collegial consultation will assume greater importance as health care reform demands more collaboration with community and health agencies. Effective consultation will include an ecological perspective based on the development of human potential.

This institute provides an overview of the human ecological model of occupational therapy consultation. Emphasis is on the particular knowledge, skills, and techniques necessary for a consultation practice focusing on helping diverse clients develop their human potential through enhancement of function and performance. Consultation concepts and process, case models to highlight the principles, and business and marketing issues of consultation are presented. [2, 3, 4, 5] Discussion and experiential activities provide the participants with an opportunity to apply principles and concepts. The consultation model based on a human ecological perspective provides the foundation to utilize the practical information and strategies presented to address rapid change.

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Title

Oral Motor/Respiratory Functions: Emerging Assessment and Treatment Strategies

Presenters

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Key Words

Sensory Integration, Sensory motor, Oral Motor, Cognition, Speech and Language, Social Emotional, Self Regulation, Visual Motor, Fine Motor, Eating, Feeding, Gross Motor, Postural Development, Posture

Abstract

At birth the mouth exhibits the most organized sensory integrative and neuromotor behaviors available to the infant. The peri-oral region is the first to respond to tactile stimuli and suck/swallow patterns are well established by 15 - 18 weeks gestation. The survival value of these developmental processes is apparent, since they undoubtedly contribute to the normal newborn's ability to find the breast and suck effectively for nutrition.

The mouth is the center of an infant's world. In addition to its importance for survival relative to feeding, the infant uses the mouth for exploration an learning about the environment, what is self and what is not. The primary oral motor mechanism is the suck/swallow/breathe (SSB) synchrony; the rhythmical, coordinated pattern of sucking, swallowing, and breathing. It is the first developmental pattern that requires timing and sequenced movements. An intact synchrony is critical to many elements of sensorimotor and cognitive development including speech and language development, state regulation, postural control, feeding/eating behavior, ego development and eye/hand coordination.

SSB has also been referred to as a "triad", probably because each component also has a distinct function. They can therefore function outside the synchrony as well as part of it. However, since all three elements are so strongly integrated, whether in automatic or voluntary patterns, it may be more helpful to think of the relationship as synergistic; each element supporting, enhancing and interacting with each other (throughout life) to varying degrees depending on the activity.

Clinical work has led to an awareness of the other aspects of development (throughout life) that may be influenced either positively or negatively by the SSB. The model outlines the relationship between the synchrony and other developmental processes and illustrates many of the processes that interact with or are dependent on normal function of the SSB synchrony. The synchrony and its components are so primal that is easy to take them for granted, but as one studies the foundations of the increasingly complex behaviors identified in the two outer circles of the diagram, it is not surprising that even subtle disruption in any element of the SSB may have a far reaching impact on development and function. The disruption need not originate from the SSB synchrony itself, but can derive from other elements that affect it, i.e. muscle tone, neurological problems, disease processes, sensory processing, etc..

It is encouraging to note that focus on treatment of SSB (at any age) can lead to dramatic improvements in the more complex areas noted on the diagram. Because the SSB synchrony is a fundamental sensorimotor pattern, it often functions as an organizer for neuromotor behavior and with careful assessment and planning can be used effectively in treatment to bring about more integrated behavior. SSB components should be routinely evaluated as part of the assessment of disruptions in development, sensory processing and integration, sensorimotor skills and/or developmental skills.

Oetter, P., Richter, E., Frick, S. (1993) MORE: Integrating the Mouth with Sensory and Postural Functions. PDP Press, Inc. Hugo, MN.

Title

Assessing Playfulness in Children

Presenters

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Key Words

assessment, play, pediatrics

Abstract

The disposition to play has been linked in a theoretical manner to flexibility of thought and adaptability (Lieberman, 1977). While these traits are important for all humans, they are particularly critical to individuals with disabilities. Thus, it may be more important for occupational therapists to promote playfulness in their clients than to facilitate the performance of particular play or leisure activities (Bundy, 1993). If playfulness is indeed critical, then occupational therapists must have both a conceptional framework for understanding it and the tools to assess it derived from the conceptual framework. Multiple conceptualizations of play and playfulness exist (Lieberman; Neumann, 1971; Rubin, Fein and Vandenberg, 1983). While a few assessment tools exist (Barnett, 1991; Leiberman), most are unsatisfactory for assessing individuals with disabilities (Clifton, 1994). Thus, Bundy and her colleagues have developed the Test of Playfulness (ToP), an observational assessment currently being used with children with children between 15 months and 10 years. The ToP is based on a conceptualization of

play developed by Neumann. In this conceptualization, play is comprised of three overlapping elements: intrinsic motivation, internal control, and the freedom to suspend reality. In addition, the ToP contains items reflecting a child's ability to give and read cues. These items are based on a concept called framing, described by Bateson (1972). Two studies (Brooks, 1995; Metzger, 1993) have demonstrated preliminary reliability and validity of the ToP. Additional studies are in progress.

Barnett, L. A. (1991). The playful child: Measurement of a disposition to play. Play & Culture, 4. 51-74

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Title

New Application in Computerized Assessment and Report Writing

Presenters

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Key Words

Functional assessment; measurement theory; computer technology

Abstract

Objective: To demonstrate the application of computer technology to environmentally sensitive assessment, and to improve documentation.

This institute introduced practitioners, managers, and researchers to a method of using computer-tailored assessment in their practice. It covered advanced topics in functional assessment measurement theory and how they are applied in the OT FACT software, Version 2.0. Specific applications of the OT FACT software included examples of the measurement system and reporting with a variety of clinical and interdisciplinary settings, and a discussion of how computer documentation can work with existing systems.

Title

Using Touch Therapeutically for Professional Sensitivity and Communication

Presenters

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Key Words

Touch
Therapeutic Use of Self
Interpersonal Relations

Abstract

The purpose of this session is to present practical methods for occupational therapists to increase their skills of therapeutic touch, which affect all areas of practice, including pediatrics, gerontology, developmental and physical disabilities, mental health, and work programs. An important component of professional and personal communication, non-intrusive touch can improve the trust level and quality of administration, management, and occupational therapy education.

Therapeutic touch has been defined in different ways. One concept is that of tactile and kinesthetic modes of therapy which focus on touch as a major mode of communication and reorganization. When defined as the direction and transfer of energy to facilitate healing in another individual, it becomes part of a wider holistic spectrum of connections between two people and the world outside themselves. In occupational therapy practice it can be a primary component of the concept "therapeutic use of self".

As in all communication, however, the message sent is not always the message received. The therapist's hands may sometimes be annoying, as light touch elicits withdrawal, or an abrupt grip causes a guarding reaction.

Touch may be brief, during assistive transfers of individuals with physical disabilities, or it may be prolonged, as in therapy sessions for cerebral palsy. The purpose of touch may be physical, with specific sensory input prescribed for sensory integration in attention deficit disorders or psychiatric conditions, or it may be social, to prevent isolation in the elderly or during terminal illness. And finally, touch is one type of non-verbal communication that therapists use in their professional and personal roles as consultants, supervisors, educators, colleagues, and friends.

This session will provide an understanding of tactile system function and the implications of touch in different cultures, age groups, and areas of occupational therapy practice. It will stress the importance of awareness and sensitivity, as specific techniques are taught within the context of intent and feelings of care and concern. Hands-on lab experiences are emphasized, as participants identify and interpret behavioral responses to initial touch, then adjust and adapt non-intrusive handling techniques.

Participants will achieve the following objectives:

1. compare the functions of intact and impaired tactile systems,
2. develop sensitivity to the behavioral responses to touch by other individuals as well as self,
3. understand the implications of touch as communication, and
4. learn specific techniques to modify handling skills for achieving non-intrusive therapeutic touch.

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Van der Loos, H. & Woolsey, T. A. (1973). Somatosensory cortex: Structural alterations following injury to sense organs.` *Science, 179,* 395-398.

Title

Aquatic Rehabilitation: Improving Effectiveness

Presenters

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Key Words

Therapeutic Exercise
Therapeutic Activity
Physical Fitness (of individual)

Abstract

Occupational therapists are utilizing the pool as a therapeutic environment in rapidly increasing numbers. The pool provides an ideal setting for addressing a wide range of occupational performance deficits through purposeful activity (Johnson, 1992). The content of aquatic programs can be readily designed to address a variety of sensorimotor, psychosocial, and cognitive goals. Strength, range of motion, and endurance programs can be carried out by using the water to provide assistance or resistance, swimming strokes to encourage limb movements through a desired range of motion, and aerobic activities to promote conditioning (Garvey, 1991; Smith, 1992). Functional activities such as ambulation and balance

are facilitated by the buoyancy of the water (Johnson, 1992). Opportunities for socialization and recreation are unlimited, and can be facilitated through water games and group activities (Johnson, 1988; Davis, 1988; Skinner & Thomson, 1983). Psychosocial goals such as coping and time management skills can easily be incorporated into individual and group activities. Attention span, memory and the ability to follow directions are just a few of the cognitive components that can be addressed during participation in aquatic programming.

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Smith R. (1992). Kids take the plunge. *Rehab Management, Dec/Jan 1992*, pp 31-36

Title

From ICU to Community: Model for Determining Effectiveness

Presenters

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Key Words

Assessment Planning
Outcome
Occupational performance
Managed care

Abstract

Individuals with stroke continue to comprise the largest case loads of occupational therapists in geriatric practice. As health reform re-shapes the practice of medicine, occupational therapists as part of the health care system, must join in the effort to provide quality care that is effective and efficient. The focuses on function requires occupational therapists to link their measurement of function to the occupational performance of the individual. Outcome information must be recorded to the extent to which patients have the skills and abilities to sustain activity that contributes to their well being.

Occupational therapists must show evidence of process and outcome linkages by relating what patients do in therapy and what patients are capable of doing at home. Practice must also reflect the underlying theories for assessment and treatment that highlights occupational therapy's unique contribution to overcome disabling conditions. This presenter will present a model built on the National Center for Medical Rehabilitation Research framework. Within the context of

this model each of the areas of performance are measured from the impairment, functional limitation to disability and societal limitation level will be presented and discussed. Preliminary data gathered from the implementation of this model at Washington University School of Medicine and the Barnes and Jewish Hospitals Departments of Rehabilitation will be presented and the clinical utility of measures to address issues of outcome and quality of life will be discussed.

Title

What's Endependence?

Presenters

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Key Words

Independent Living, Consumer Centered Practice

Abstract

Simultaneously, persons with physical disabilities and persons with mental illness are involved in a movement to change the manner in which health care services are provided. Although health care providers are involved in this movement, the loudest and most convincing voices come from the consumers themselves. The Independent Living Movement represents many individuals with physical disabilities who advocate empowerment for the consumer. Although not represented by one organization, many individuals with mental illness are championing the same cause. Interestingly, occupational therapists have been slow to embrace this model of practice even though the emphasis on independence and normalization in living and working environments is consistent with the profession's philosophical base.

In 1979, Dejong's landmark article was published elucidating a paradigm shift from a rehabilitation to an independent living philosophy which focuses the problem and the intervention such that the environment is seen as the primary obstacle to independence with removal of barriers, consumer control and self-help as the solution. Several occupational therapists have reviewed the profession's association with these ideals. Bowen (1994) found that less than half of the Independent Living Centers she studied employed occupational therapists. Kleinman (1992) suggests that occupational therapists working in mental health adopt a social model that emphasizes environmental and social barriers as causal factors.

This program is designed to provide occupational therapists with the information necessary to apply these alternative models of practice so that they become major service providers in consumer-oriented, community-based settings. This institute provides background information on the history of the movement, policies, legislation and ethical considerations related to consumer oriented practice. Assessment, planning and intervention practices at the participants' work settings are reviewed so that the implementation of specific and relevant consumer oriented strategies can be discussed. Consumers participate in the process by presenting their personal experiences and assisting with the application discussions.

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Title State Legislative/Regulatory Issues

Presenters

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Key Words

legislation
occupational therapy
policy making

Abstract

The role of occupational therapists in the legislative arena has grown in the past decade (Moyers, 1991, Brayman 1994). Awareness has increased along with a commitment to proactive involvement in shaping public policy. Social changes such as those inherent in health care reform legislation invite therapists to refocus their ideas, prioritize agendas and articulate clearly their scope of practice, and its uniqueness. Professional identities have become blurred, as a result of not fulfilling the needs of the consumers served (Bruhn, 1993). Occupational therapists must explain how the profession continues to meet societal needs of the consumer in a unique manner to survive in this era of health care reform. Occupational therapists have the opportunity to propose their position in this new environment within pending and proposed legislation on health care reform. To justify the uniqueness of the profession, it is suggested reflecting upon the

philosophical base prior to proposing the role occupational therapists will play in health care reform.

Occupational therapists in Kentucky have been active participants in monitoring legislation that will have an impact on service delivery. Legislative and regulatory issues confronting the profession in Kentucky during the past two years have been challenging. In discussing the issues raised within health care legislation in Kentucky, the structure of the General Assembly must first be presented, to understand key components involved in this state.

The Commonwealth of Kentucky General Assembly meets once every two years for 60 days. During the 1994 General Assembly, House Bill 250 - The Health Care Reform Act was signed into law. This legislation has two major areas of concern for occupational therapists: managed care and the role of OT and cross-disciplinary training. A five person Health Policy Board was appointed by the Governor to develop and implement directives within the law. Major issues of concern to occupational therapists include services in the health benefit plan and cross-disciplinary training of professions. Development of plans for implementation are to be in place by January 1996.

The Kentucky Occupational Therapy Association is actively tracking the development of recommendations made by the Health Policy Board and serves as a resource for information to this decision-making group. Occupational therapists in Kentucky have developed strategies to best represent the interests of the profession on health care issues that will affect service delivery. Cross disciplinary training has encouraged therapists in Kentucky to relook at the theoretical and philosophical base of the profession, as a foundation for discussions. Occupational therapists have strategized in presenting their case as professionals, without being perceived as self-serving by policy makers. Action plans will be shared in this presentation, along with barriers encountered. Professional ramifications will be presented.

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H.B. 250 - 1994 Kentucky State Legislature. Health Care Reform Act.

Title

QI, PE, CQI, TQM, OM, OIP...Are we all saying the same thing?

Presenters

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Key Words

Outcome Assessment (health care)
Program Evaluation
Quality of Health Care

Abstract

QI, PE, CQI, OM, OIP, functional outcomes...These terms are mindboggling, confusing, frequently heard, and yet not clearly understood in today's healthcare environment.

All of us are faced with major changes in the health care industry (i.e., health care reform, managed care, further restricitions by third party payers, and increased competition from less costly providers). In addition, many of us are drowning in the paperwork demanded by reimbursers and accreditation bodies.

These are demands for OTs to demonstrate the cost effectiveness, quality, and outcome of our programs, to use this information to manage effectively and improve our services; and to justify our existence. Yet this task is often difficult if confusion exists regarding what these terms mean; and, how we cna simplify our systems and process to make them more outcome driven, patient-centered and cost effective.

This one day institute will cover the following learning objectives:

1. Participants will be able to define the various terms used in the "language of quality."
2. Participants will begin to develop an appreciation for the big picture in quality and rehabilitation.
3. Participants will be introduced to the Joint Commission on Accreditation of HealthCare Organizations' (JCAHO), the Commission on Accreditation of Rehabilitation Facilities' (CARF), and the Accreditation Council's (AC) outcomes and quality.
4. Participants will learn how to manage their existing data into integrated systems to reduce redundancy, meet accreditation standards and demonstrate an ability to measure and manage quality and outcomes of OT services.

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Title

Management Information: Can You Deliver?

Presenters

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Key Words

Management Information System

Abstract

In response to the demands created by third party payers, regulatory agencies, and competition, rehabilitation programs are searching for ways to maximize quality while reducing costs. To do this, we must collect information on our customers, our services, our costs, and our outcomes. Searching for an efficient and effective way to manage this information can be a confusing and time-consuming task. This institute developed an information management model which distinguished among clinical outcomes, nonclinical outcomes, and other informational categories which can be captured in an Information Management System. This model clarified the relationship among Information Management Systems, Program Evaluation, Outcomes Management, and Quality Improvement and identified the scope of an Information Management System. The rationale for an Information Management System, which includes accreditation and regulatory demands, fiscal accountability, competition, the quality movement, and declining reimbursement, was presented. In this presentation, the elements of a

comprehensive Information Management Program were detailed with examples; and, suggestions to assist in evaluating and justifying needs, making decisions, and acquiring hardware and software relative to developing an Information Management System were provided. When properly designed, Information Management Systems should be the source of information for strategic planning, budgeting, marketing, program evaluation, quality improvement, productivity, outcomes management, financial reports, and documentation monitoring. Suggestions for displaying, analyzing, and communicating results for these uses were discussed.

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Title

Principles of Consultation: Occupational Therapy in Community Programs

Presenters

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Key Words

Consultation, community-based practice, program development

Abstract

This institute will present the knowledge and skills needed for occupational therapy practitioners to serve as agents of change in the evolving system of health services. By acquiring the ability to provide consultation, the profession has the potential to emerge as a primary service in community health.

Health reform is nudging service delivery toward broader community-based programming. Various proposals for the re-design of health systems suggest that greater responsibility for health will rest with the consumer and that cost reduction depends on increasing home health and service delivery in the community.

Occupational therapy has a distinct role to play in health reform by consulting to community-based programs. Given our long history in direct service, consultation is an expanded role for many practitioners. This institute will provide guidelines for developing consultation skills with a focus on program planning and development. Program design is dependent on knowledge of trends analysis and funding patterns for health. Additionally, the ability to

identify model systems of health and education service delivery is essential to program development. Within the context of environmental and system resources and constraints, the next step is to define the specific and unique role occupational therapy does and can play. Once the program is developed, there is a need to market the program and promote occupational therapy. Formative and summative evaluation is an integral aspect of program development.

This institute will combine lecture/discussion with individual and small group activities in addressing the principles of consultation. Copious examples will be used to illustrate those principles. Both authors have collaborated on the design and implementation of occupational therapy consultation in a community psychosocial program, Way Station, Inc. What, how, when, and where occupational therapy contributed to the overall program was carefully articulated into a valuable niche that complemented the full program. Occupational therapy's role in program development included collaboration on the mission and goals of the program and the use of occupational therapy consultation to enhance the clubhouse model. The program also benefitted from consultation on the design of a comprehensive work evaluation, development of intervention strategies to build work skills, and orientation of full-time staff to intervention goals and approaches.

Upon completion of the workshop, participants will be able to:

1. define and describe the consultation role in occupational therapy;
2. identify the major principles of consulting in program development--trends analysis, identification of funding patterns, definition of health systems, clarification of occupational therapy's role in consultation, developing a community-based program, marketing and promotion, and evaluation; and
3. apply the principles of consultation in developing occupational therapy in his/her community.

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Title

Developing Hand Skills in the Child: Handwriting and Manipulation

Presenters

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Key Words

Hand Functions, Handwriting

Abstract

Acquisition of hand skills is critical to the child's ability to function in school and home environments. McHale and Cermak (1992) reported that children in Grades, 2, 4, and 6 from their study spent from 31 to 60 percent of their school day involved with fine motor tasks. For a child having difficulty with handwriting or the performance of other fine motor tasks, the pediatric occupational therapist often evaluates a child's fine motor abilities and functional skills. The occupational therapist may then assist the educational or clinical team in planning and implementing an intervention program for the child who is having an occupational performance deficit.

Recent advances through research have been made in the assessment and intervention approaches related to the development of children's hand skills, in-hand manipulation, and handwriting. The burgeoning of new theoretical information related to the neurophysiological mechanisms neccessary for hand skill along with the most recent

evaluation and treatment techniques of in-hand manipulation skills and handwriting, makes staying abreast of current literature difficult for occupational therapy practitioners. It is imperative for relevant, up-to-date information to be presented to practitioners in order for them to be implementing "best practice" in the area of pediatric occupational therapy.

This institute focuses on neurophysiological mechanisms, occupational therapy frames of reference as well as specific therapeutic strategies related to children who have fine motor dysfunction. From their individual perspectives, each presenter will discuss the importance of fine motor function in children's occupational roles and in their natural environments (e.g., home, school community).

Each of the three presenters will discuss a specific are of fine motor function and weave a case study of a child with poor hand skills throughout the conceptual information presented. The theoretical and research base for understanding the central nervous system control over precision movements of the hand will be presented. Emphasis will be placed on the particular role of cortical structures in the mediation of skilled hand function (Kuypers, 1981). Evaluation and intervention of children's in-hand manipulation skills, the work of Exner (1990, 1992) will be described from neuromotor and functional perspectives. A comprehensive model of handwriting intervention will also be presented building upon the previously presented information. Effective collaborative strategies and specific therapeutic techniques for improving children's handwriting in the classroom will be discussed (Graham & Miller, 1980).

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Title

SCHOOL DIVERSITY: STRATEGIES FOR BRIDGING CHILDREN"S CULTURAL WORLDS

Presenters

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Key Words

SCHOOLS, PEDIATRICS, CULTURE

Abstract

School therapists increasingly recognize the need to make occupational therapy educationally-relevant and family-centered. Clinical reasoning about how to accomplish this while addressing the needs of the individual client becomes more complex as therapists try to respond to a variety of client cultures. When focusing on cultural diversity, we tend to assume that everyone has one culture. However, each person participates in multiple cultures. Race and ethnicity represent only one level of cultural diversity. Families, workplaces, institutions, and professions, as well as classes and neighborhoods, also constitute cultural worlds.

This institute will address multi-cultural dimensions of occupational therapy practice in schools by helping therapists more fully understand the multiple worlds of their pediatric clients. Key objectives are to enrich therapists' understanding of

multi-culturalism in school settings, to help therapists learn to assess the nature of the multiple worlds of children in particular school settings, and to help therapists develop strategies to help clients function in these disparate and sometimes confusing worlds.

In a three year ethnographic study of Latino and African-American children in special education, the presenters found that children were forced to serve as "culture brokers" - to negotiate among and function in the different worlds of family, community, and classroom. For children with special needs, this negotiation can become quite difficult when the cultural worlds of family, community, classroom, and therapy collide rather than reinforce one another. What is the appropriate role for occupational therapists in helping a child function at his or her best in traversing these differing worlds? What skills and what sort of clinical reasoning is needed for the therapist to support the child in such circumstances?

The presenters will utilize lectures, combined with videotapes, audiotapes, and interview transcripts to describe the multiple cultural worlds of the special needs child. Special emphasis will be given to the classroom world and the home world. Participants will, in effect, "follow" the minority special needs child into the classroom and family worlds, and will consider the important skills that child needs to function in those worlds.

In addition, participants will share key "stuck points" and successes from their own experience in trying to: a) work with children from diverse cultural backgrounds; b) collaborate with parents, teachers, and other school professionals on therapeutic and educational goals; and c) help children to improve their functioning in multiple cultural worlds. In presenter-guided break-out sessions, participants will relate stories from their own professional experience to the themes of the institute..

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Mattingly, C. and Fleming, M. (1994). *Clinical Reasoning: Forms of Inquiry in a Therapeutic Practice*. Philadelphia: F. A. Davis.

Title

Considerations For A Driver Rehabilitation Program

Presenters

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Key Words

Driver Rehabilitation
Driver Education

Abstract

With the improvement of emergency medical technology and the advancement of health care, persons with congenital, adult onset or traumatic diagnoses have increased chances of survival. Demographic changes in the U.S. reflect a dramatic increase in the number of disabled people who are living longer. The advent of the Rehabilitation Act of 1973 and the Americans With Disabilities Act (ADA) of 1990 reflect the increased awareness and concern of society and government for the welfare and rights of persons with disabilities.

The personal automotive vehicle is frequently the only means of independent mobility available to an individual. As one young lady with quadriplegia stated, "Accessibility with mobility is an effort in futility." Accessible transportation, as reported in the 1986 ICD Survey of Disabled Americans, is a barrier restricting the activities of 49% of Americans having mobility limitations. For the work-age population, approximately 25% of those reporting disabilities say that they cannot work due to lack of affordable, accessible transportation to work. There are over 430,000 wheelchair users in the U.S. alone, many of whom have been primarily limited to moving about in the confines of their homes except for occasional trips with a relative or dedicated friend. These individuals today hope that the strong regulations outlined in the ADA will improve their opportunities for having independent mobility in the community.

Each year many more Americans and their families have need to ask whether, at the onset of disability or in the face of advancing age, the license to drive should be attempted, limited or even taken away. As we approach the twenty-first century, the total success of a rehabilitation program aimed at increasing the independence and opportunities of persons with disabilities will be largely dependent on the ability of the health care provider and community to provide realistic access to private and public motor vehicle transportation. There are approximately 5,000 health care institutions in the U.S. that are members of the American Hospital Association (AHA). Less than 1% of all of these institutions have driver rehabilitation programs represented through the Association for Driver Educators for the Disabled (ADED).

AHA facilities will want to meet rising consumer demands by developing a driver rehabilitation service. An occupational therapist's educational/medical background and experience with assistive technology, compensatory techniques and activity analysis is ideally suited to the driver rehabilitation specialist's role. Approximately 450 therapist/assistants hold membership in the ADED; 300 therapists/assistants indicated in the 1990 AOTA Member Data Survey that they provide driver rehabilitation services. The number of OT practitioners with expertise in driver rehab services is woefully inadequate to meet the rapidly escalating demand for this service.

As driving is one of the most difficult and dangerous activities that a person can pursue, a facility or therapist should take on this task with extreme caution, research and planning. After a formalized plan of action has been pursued, the following questions should be considered:

1. What is the facilities' commitment to provide the finances and support to develop a viable and comprehensive driving program?
2. Can the therapy department's budget afford a program?
3. Is there an adequate referral base to justify a comprehensive driving program and its costs?
4. Is there a therapist that is genuinely interested in staying with a driving program so that the costs of training, etc., can be justified?

Final advice to any facility or person considering becoming involved in a driving program:

1. After much research, it may be decided that it is more cost-effective and practical to set up a referral network with another established program.
2. A good pre-driver screening program can be very effective and a good service to provide, although you should know other resources to send a client to for an in-vehicle assessment. A determination of a person's driving capabilities should never be assessed without an in-vehicle assessment.
3. It is important to start small and slow to build a solid foundation. The program should be started with a car so the therapist can become very knowledgeable in all equipment available on this vehicle before progressing to the more complex van equipment.

Title

A NEUROFUNCTIONAL APPROACH TO REHABILITATION FOLLOWING SEVERE BRAIN INJURY.

Presenters

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Key Words

Brain Injury • Rehabilitation • Behavior

Abstract

1. Introduction: The Neurofunctional Approach

This institute examines the application of neurobehavioral and neurofunctional skills training to severely brain injured adults. The approach is based on learning theory. The literature on the models application to brain-injury rehabilitation is reviewed.

2. Recovery and Rehabilitation Models

Patterns of recovery-of-function and application of models-of-intervention in varying stages of recovery are outlined. Discussion includes neurophysiological and behavioral theories of recovery.

3. Attention, Memory and Initiation

The constraints placed on human learning by brain injury will be examined. A theoretical model based on current research will be described. Recent research on memory, attention, planning and initiation will be examined and specific implications for training brain-injured adults of varying degrees of impairment are made. The role of the frontal lobes are described. The authors model for conceptualizing frontal lobe functioning after brain-injury is described.

4. Interventions for Behavior Disorders

Behavior management techniques will be taught to participants. Training will occur so as to provide participants with a model for teaching others in the treatment team. The place of occupational therapy in the interdisciplinary team will be discussed.

5. Interventions for Functional Skills Deficits

Discussion of neuroscience research and learning theory will be applied to specific occupational therapy interventions. The importance of using the patient's entire environment to assist them to learn will be emphasized. Special emphasis will be placed on adapting occupational therapy intervention for the behaviorally disordered or noncompliant individual.

6. Case Study Workshop

Two detailed case histories are presented. The results of interdisciplinary patient assessments will be presented to participants as a starting point for examination of possible interventions. Participants will develop their own intervention plans.

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Title What's New in Job Site Analysis

Presenters

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Key Words

Back Injuries
Human Engineering
Preventive Health Services

Abstract Job analysis is a service commonly offered by occupational therapists in industrial rehabilitation and worksite health promotion. However, occupational therapists are not the only professionals offering this service. Physical therapists, safety directors, occupational health nurses, vocational specialists, ergonomists, industrial hygienists and loss control engineers all consider themselves specialists in job site analysis. External forces are pressing these diverse groups to validate their expertise in order to hold their position in the marketplace. Allied health professionals have recently been challenged by the ergonomic certification process conducted by the Board of Certification in Professional Ergonomics. In addition, new OSHA ergonomic guidelines may promote the use of certain professional groups to perform job site analysis.

Occupational therapists performing job analysis often overlook the role of the environment for the worker being able to perform the job safely and efficiently. Noise, lighting/color and vibration are three environmental conditions occupational therapists can screen at the workplace using specialized equipment and advanced training. The assistance of an ergonomist, industrial hygienist or engineer

may be required to thoroughly evaluate the environment and make appropriate modifications. (Eastman Kodak Company, 1983; Picone P, 1995; Grandjean E, 1983; Chaffin D and Anderson G, 1984)

Most occupational therapists measure the physical demand parameters required at the job including lifting and reaching. Three formulas are available which allow therapists to assess safe lifting of a specific task by calculating spinal compression forces. The 1991 Revised NIOSH Lift formula applies to two-handed inanimate lifting scenerios (Walters TF et al, 1993). The Bloswick measure of compressive forces does not limit the evaluator to inanimate objects and can be applied to lifting and lowering tasks involving people and animals (Bloswick 1993). Both the NIOS and Bloswick formulas utilize the maximum allowable compressive force for healthy young workers. Acknowledging that many health care workers are not young and/or healthy, Genaidy et al developed a formula which allows the therapist to incorporate the gender and age of the worker when calculating safe lifting tolerances (Genaidy et al, 1993).

Occupational therapists can better serve their clients and referral sources by including environmental assessment and calculation of spinal compression forces when performing job analysis. By using objective data available in the literature, occupational therapists will be able to provide validation to the efficacy of their work.

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GENERAL INTEREST

Title

Issues of Gay Men and Lesbians with Disabilities

Presenters

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Key Words

Homosexual-Disabled-Attitudes-Toward
Sexual Orientation
Cultural-Sensitivity

Abstract

The *Uniform Terminology for Occupational Therapy - 3rd Edition* lists sexual expression as an Activity of Daily Living (ADL) to be addressed in Occupational Therapy treatment. It has been documented that patients who have a satisfying sexual relationship are more positive, socialized, and have an increased desire to resume work. A positive sense of sexual identity is a powerful integrating factor in the resumption of life roles. Yet, Occupational Therapists work within a healthcare system that denies patients' sexuality or negates sexual concerns outside that of the heterosexual majority.

Aside from AIDS, little research has been published concerning homosexuals with disabilities. This is, perhaps, due to invisibility and the assumption that issues surrounding disability are the same regardless of sexual orientation. The problem of non-acceptance by both the disabled and the homosexual communities, fear of loss of services or alienation of

family and health care workers, and lack of positive role models for disabled gays and lesbians often preclude the "coming out" process. Stigmas and stereotyping originating internally and externally to the homosexual disabled community stifles development of a positive identity. Furthermore, many groups for the disabled exert considerable pressure to conform to the norm. The disabled themselves are no more accepting of homosexuality than is society in general.

Other issues include the paucity of information available on sexuality or sexually transmitted diseases for various diagnostic groups, the preponderance of heterosexist descriptors in facility documents, and the excluding behavior of "looksism" in gay male culture. Couples face further discrimination due to legal non-recognition, raising issues of insurance coverage and guardianship.

The neglect of a person's sexual orientation not only impedes the person's rehabilitative progress, but further reinforces depression and lack of self-esteem. It is the responsibility of the Occupational Therapy professional to become an educated advocate for the sexual rights of **all** persons with disability, and to help bridge the distance between the disabled and able-bodied communities.

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Title

Everyday Ethics

Presenters

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Key Words

ETHICS, MORAL TREATMENT, OCCUPATIONAL THERAPY [PROFESSION OF], MINORITY GROUPS

Abstract

This three-hour workshop will explore issues of nondiscrimination and inclusion regarding members of the occupational therapy professional community. Presenters will explain the current documents of the Association that relate to topic as well as discussing the concepts of moral inclusion and exclusion.

To exemplify the issues involved, three members of the profession will give examples of their own and others experiences of being discriminated against and excluded in the professional community.

The workshop will conclude with an open discussion among the participants and the presenters about strategies that we all can use to be equitable and fair to our professional colleagues.

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Title

Home and Community Health SIS Program: Occupational Therapy Goes Home

Presenters

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Key Words

home health

Abstract

This workshop addresses occupational therapy intervention provided in the home. The focus of the workshop is assessing the patient's strengths and needs in the context of the physical, social and cultural environment, and developing strategies to incorporate the strength to meet the need areas.

As the venue for rehabilitation shifts from the hospital to the home, the demand for home health occupational therapy services increases. However, traditional treatment approaches designed for the hospital environment do not address the full scope of needs faced by the patient upon returning to the home. While in the hospital, treatment focuses on symptomatology related to the diagnosis; in contrast, home health intervention is based on the patient's needs in the context of their physical, social and cultural environment. Problems may include environmental hazards or obstacles, caregiver limitations, disruption of

familiar routines and loss of valued roles, and emotional and behavioral changes related to the disability.

The occupational therapist working in home health care is challenged to develop skills and treatment approaches that adapt to the context of the individual patient environment. Skills the patient learned in the optimal hospital environment, with physical accessibility and 24 hour skilled care, must be adapted to the constraints of the patient's home setting. Other tasks are identified which may be crucial to the patients ability to live safely at home, such as the ability to exit in emergency and the ability to use the phone. The occupational therapist must also recognize the expectations and the abilities of unskilled caregivers and adjust expectations for follow up accordingly. Cultural values regarding illness, independence and the role of family all determine the goals of treatment. Adjustment issues must also be addressed, as the patient faces a loss or change in his or her ability to perform valued or even routine tasks in the familiar home environment. For many patient, the loss of function is faced as they realize they need assistance to even enter the home they longed to return to.

Home health care provides an opportunity for occupational therapists to integrate deeply held professional values with innovative treatment approaches. Working within the patient's home, family and cultural context, occupational therapy empowers the patient to resume valued life activities. Home based intervention provides unique challenges, frustrations and rewards.

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Title

Effects of Culture-Specific Long-Term Care on Well-Being

Presenters

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Key Words

Subjective well-being
Activity participation
Long-Term Care

Abstract

Differences in levels of subjective well-being(SWB) and activity participation were examined between a group of 16 first generation (Issei) Japanese individuals with a mean age of 88 years, and a group of 14 second generation (Nisei) Japanese individuals with a mean age of 79 years residing in a LTCF with a strong Japanese cultural focus. The Philadelphia Geriatric Center Morale Scale (PGC Morale Scale) was used to measure overall SWB and three subscales of SWB (Agitation, Positive attitude towards aging, and Loneliness dissatisfaction). Levels of activity participation were determined by calculating the number of minutes residents participated in religious, passive, and active structured activities offered by the LTCF. The Issei group expressed less agitation, a more positive attitude towards aging, and less loneliness dissatisfaction. The Issei group also had higher mean levels of activity participation in religious, passive, and active activities. A significant difference was found for Issei participation in religious activities.

Title

LIFE ROLE DEVELOPMENT AFTER A SPINAL CORD INJURY

Presenters

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Key Words

Qualitative Research, Theory, Occupation, Roles, Employment, Spinal Cord Injury

Abstract

A qualitative, comparative case study design [1] was used to explore the processes involved in human occupation and re-entry to employment after a spinal cord injury (SCI) [2]. Given the impact of the consumer advocacy movement and the Americans with Disabilities Act upon disabled individuals' ability to return to work, coupled with the changing nature of work in this Information Age, a study which re-explored human occupation was timely and offered insights into the effectiveness of occupational therapy (OT) interventions. Using a purposive sampling approach [1], nine participants with SCIs were followed as they attempted to return to work. The sample represented a diverse group in regard to level of disability, gender, race, and ethnicity. To meet guidelines of rigor and accuracy, data were triangulated through multiple methods including participant observations, videotaped interviews, visual maps, and document reviews. To account for bias, data were coded by three reviewers.

Expanding upon OT models [3, 4], a grounded theory, referred to as the Life Rope Theory of Role Development (LRT), emerged [2]. Based upon the metaphor of a rope, the individual's role repertoire is represented as a life rope . The multi-stranded life rope is composed of three role layers including the core identity strand (person's self esteem and belief in competence), a surrounding layer of basic survival roles (e.g., employer of attendant care and assistive technology user), and one or more layers of outer elective roles (e.g., student, worker, and social support). Role strands may be added, deleted, or shifted among layers depending on the importance placed upon them by the individual, and the demands of the contexts and society

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in which he or she operates. Participants experienced a cut to this rope with the SCI, and then underwent a developmental process to reweave a new one [2].

Based on this study, recommendations for improving the effectiveness of OT role development interventions and a computer-based program which allows consumers and OTs to collaboratively create life ropes and intervention plans have been developed.

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Title

Elder Computer Interaction Project

Presenters

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Key Words

Single subject research; Computers; Depression

Abstract

This innovative pilot research project was stimulated by literature in aging which pointed out that elders who enter a nursing home are much more likely to become depressed and dependent, and to experience cognitive decline. From an occupational therapy perspective this is not surprising given all that one gives up in terms of environmental richness and daily choice, not to mention whatever losses of function necessitated the move into a nursing care facility. It is important to address this depression, dependence and cognitive decline, not only for the resident's quality of life, but also because such factors add to the amount and therefore the cost of care.

In this research three graduate students and the author looked at whether involving selected nursing home residents in meaningful computer interaction could have a positive effect on their depression, dependence and cognition. The method used was a single-subject, multiple-baseline, multiple-probe design. Using behavioral criteria the director of rehabilitation at the facility

selected four residents to participate as subjects. Informed consent was obtained, and all four subjects were assessed within the same two-day period,(probe 1) using the following instruments: the Geriatric Depression Scale for depression; the Parachek for dependence; and the LACL for cognitive level.

Meanwhile a daily check sheet was developed, with one five-option behavioral measure for each variable to be observed by the aides at 7:30 a.m., and a different five-option behavioral measure for each variable to be observed at 10:30 a.m. The aides were trained, a one week trial was undertaken during which the aides were shadowed, and the check sheet was modified based on their feedback. Analog reliability of the daily check sheet was tested using residents other than the research subjects.

After the first probe a month of baseline data was collected on all subjects, using the daily check sheet. Then a second probe was done, after which the first subject was introduced to the computer using a standard format developed by the research team. The activities the researcher then helped the subject move into were decided based on an interest inventory which had been done earlier with that subject. Most activities were accessed through a national online service. Each researcher kept a narrative log of observations made while working on this project.

After the second month, when the first subject had been using the computer three times a week for about four weeks, the third probe was completed on all subjects. Then the second subject was introduced to the computer. This pattern continued for six months.

Results were in three forms: quantitative data from the five monthly probe assessment batteries; visual data from the plotting of the daily check sheet scores; and qualitative data from the logs kept by the researchers. Although there were changes in scores on the probe assessments, they were not statistically significant. The baseline data from the daily check sheets also did not show any significant change. Information and observations noted in the logs did show change, particularly a decrease in depressed affect in one of the subjects. This change was also noted by social work and nursing in this subject's medical chart. This improvement was first noted after the subject had been using the computer for a month, and was attributed to her participation in this project.

Based on this pilot project the researchers concluded the following: 1) the probe assessments were too global to note small changes in each of the variables; 2) the behavioral measures developed for the daily check sheets need to be further refined; 3) criteria for inclusion of subjects need to be more selective; 4) meaningful computer interaction did have a positive influence on depression in one of the four subjects, as observed by both the researchers and the nursing home staff.

Title

The Role of Practice Context in Clinical Reasoning

Presenters

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Key Words

decision-making, professional practice, professional education

Abstract

The literature on clinical reasoning in occupational therapy has primarily been directed to therapists' decision-making using a combination of scientific or narrative approaches (Rogers,1983, Mattingly & Fleming,1994). A number of others have suggested that factors from the practice context, such as caseload size and reimbursement are barriers to effective clinical reasoning. Schell & Cervero (1993) have suggested that attention to practice context is an inherent part of clinical reasoning. To explore the empirical support for this contention, the study being reported was designed to examine the influence of practice context on occupational therapists' clinical reasoning.

As clinical reasoning cannot be directly measured, therapists' treatment interventions were chosen to reflect their reasoning. This permitted analysis of relationships among treatment approaches and practice context factors. The purposive sample consisted of 49 registered occupational therapists practicing in five health care organizations. The percentage of time therapists spent using passive, enabling or purposeful activities in treatment was selected to indicate clinical reasoning. Each therapist was observed during one treatment, during which therapy activities were timed, logged and categorized according to type of activity. Treatment activities were categorized according to whether they involved passive, enabling or purposeful

activity. All treatments involved adults with physical and/or cognitive impairments.

Program type, treatment site, caseload and physical resources were selected to reflect important aspects of the practice context. Program types included inpatient acute, inpatient rehabilitation and outpatient services. Treatment sites included bedside, clinic and natural contexts.

Analysis demonstrated systematic variance within this sample as a function of practice context. Multiple regression showed multiple R for all four variables from the practice context was .34 for passive, .54 for enabling and .62 for purposeful activities. The strongest unique contributions were made by program type and treatment site. Program type uniquely accounted for 20% of passive activity use, 21% of enabling activity use, and 34% of the use of purposeful activity. Treatment site uniquely accounted for 5% of passive activity use, 12% of enabling activity use, and 11% of purposeful activity use. The additional variables of caseload and physical resources did not make unique contributions, but anecdotal data did support their importance. These results support a view of clinical reasoning as involving attention to the practice context as well as the patient or client situation. Implications include the importance of attending to the practice context during professional education and human resource development.

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Title

ROLE DIVERSITY: COTAs, A SOURCE OF PROFESSIONAL STRENGTH

Presenters

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Key Words

Intra-Professional Relations
Trends, Occupational Therapy
Occupational Therapy Personnel

Abstract

OTRs as well as COTAs are invited to consider the diversity of roles within the field of occupational therapy with the focus on the role of COTAs in this forum. Individual and organizational values and behaviors which promote or impede an inclusive professional community will be examined. As the numbers and roles of COTAs have evolved, long standing problematic issues demand resolution. In 1995 COTA education programs have increased to include 93 accredited (90 at associate degree), 23 developing and 9 having applied for a total of 125. This compares to 36 accredited programs (23 at associate degree) in 1973. Changing health care delivery systems have compounded these problems as well.

Several historical indicators will be reviewed which reflect continued dissonance within the profession (i.e. role confusion, supervision issues, and 6 resolutions in 24 years calling for a title change for COTAs with the recurring conclusion being that it is not an issue of semantics but indicative of deeper conflicts). Ingredients which make diversity a strength or a source of division will be explored. A model used to understand discriminatory behaiors will be utilized to analyze structures and expectations which have limited COTAs.

AOTA actions taken to address problems include adding a COTA to the R.A. in 1985, a COTA on the Executive Board, a COTA Network, and a COTA Program Manager at AOTA. Emerging solutions are being developed by the Advanced Competiencies Task Force, the COTA Issues Committee, and the COTA Educational Unit Committee.

External societal pressures also demand resolution of these internal conflicts. A more diverse population expects representative diversity from service providers. Ability to provide such diversity seems to lie more readily within the potential of OTA programs rather an OT programs according to the AOTA Educational Data Survey. Changes in health care delivery have called for OT personnel beyond current resources. American Council of Education statistics demonstrate the greatest area of growth in higher education is within two year postsecondary institutions.

Contemporary managerial practices transforming American work environments expect shared responsibility, a high regard for individual worth, use of data for decision making, and collaborative relationships. Stephen Covey, J. Edward Deming, John Carver and Peter Senge are a few who are contributing to this transformation. The profession of OT, if not already subscribing to these management principles, will need to quickly incorporate them to build effective teams.

New paradigms will need to be developed in which COTAs provide solutions to some of the internal and external pressures and in which OTRs and COTAs consider improved methods of discourse and policy making. This forum will facilitate discussion and challenge how the profession views COTA roles as well as how the profession makes practice and education decisons. Ultimately, AOTA will be challenged to strive for greater congruity and visionary leadership with its mission, which proclaims a professional community, and with actions to ensure inclusion. Ideally this forum will open new opportunities for partnering and collaboration between OTRs and COTAs.

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AOTA (1994) Education Data Survey Final Report

Title

Occupational Therapy Practice and Education in Mexico

Presenters

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Key Words

1. International Linkages
2. Occupational Therapy in Mexico
3. Educational Program Development

Abstract

Mexico is not a member of the World Federation of Occupational Therapy (WFOT) since they do not have an accredited school of occupational therapy. With the passage of the North American Free Trade Agreement (NAFTA), new opportunities exist for collaboration with Mexico in health care education and services. Toward the objective of increasing the educational status of occupational therapy in Mexico, a unique collaboration developed between a national and state OT organization and an academic OT program. A delegation from the occupational therapy department at the University of Texas Health Science Center at San Antonio, the American Occupational Therapy Association (AOTA), and the Texas Occupational Therapy Association (TOTA) visited Monterrey, Mexico. Meetings at the University of Monterrey, the Secretary of Health for Nuevo Leon, and rehabilitation centers provided new contacts and knowledge about the current development of occupational therapy in Mexico. Subsequently, opportunities have continued for collaboration with health professionals in Mexico. American occupational therapists were invited to present rehabilitation information at an international conference in

Mexico, a fieldwork contract was made with a Mexican clinic, and occupational therapists from Monterrey co-presented at an American conference. Relationships between the United States and Mexico have increased awareness of cultural differences that substantially impact the development of professional level occupational therapy programs in Mexico. Cultural attitudes in Mexico also hinder rehabilitation efforts toward promotion of independent function. Although clinical skills and techniques of occupational therapists in Nuevo Leon are similar to that used in the United States, they are more creative in their application and do not have the benefit of technology. The University of Texas Health Science Center at San Antonio is continuing to provide consultation and linkages with universities in Monterrey who are considering occupational therapy program development or expansion. Ten keys to success and pitfalls to avoid for international linkages with academic institutions were presented in respect to the Monterrey, Mexico initiative.

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Title

Successfully Promoting Yourself and Your Profession

Presenters

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Key Words

Public Relations
Communication
Consumers

Abstract

Promotion of occupational therapy is becoming increasingly important in today's changing healthcare environment. With the growing utilization of managed care, consumers have a greater role in deciding which services they ultimately receive. Occupational therapy practitioners are also finding they need to promote themselves more effectively within their facilities, in light of economic pressures leading to trends such as cross-training and the demand for multi-skilled practitioners. And practitioners also recognize that OT is competing with other health professions for our share of media attention, as well as the healthcare dollar.

Greater and more effective promotion of occupational therapy can have a positive impact on legislative efforts such as healthcare reform, reimbursement, funding for education, licensure and other regulatory issues. Promotion can enhance the marketing of a private practice. Finally, a working knowledge of promotional techniques can help the

occupational therapy practitioner increase his or her self-confidence and ability to articulate clearly and succinctly an answer to the question, "What is occupational therapy?"

In this workshop, three public relations professionals from the AOTA National Office provide practical suggestions on how to promote your profession—and yourself—to consumers, other healthcare providers, and the public through the media.

See *Promoting the Profession—A Resource Guide for Marketing and Publicizing Occupational Therapy*, Suzanne Carleton (Ed.). Rockville, Md.: The American Occupational Therapy Association, Inc., 1994.

Title

Cultural Diversity: An Integral Aspect of Practice

Presenters

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Key Words

culture (sociology) • education • occupational therapy services

Abstract

While multiculturalism has been a topic of interest in education for more than a decade (Banks, 1991; Bennett, 1990; Tiedt and Tiedt, 1990), the occupational therapy profession has recently indicated attention to cultural diversity with special issues of *AJOT* (Viseltear, 1992) and the *Education SIS Newsletter* (Kramer, 1992) in 1992 and the addition of context as the third occupational performance dimension in the third edition of *Uniform Terminology* (American Occupational Therapy Association, 1994). According to *Uniform Terminology for Occupational Therapy--Third Edition*, the context dimension includes temporal aspects and also the environment with physical, social, and cultural features. The cultural feature consists of customs, beliefs, activity patterns, behavior standards, and expectations accepted by the society of which the individual is a member; political aspects; and opportunities for education, employment, and economic support.

Although identified as important to the occupational therapy discipline, cultural diversity is often overlooked during the occupational therapy process of screening, evaluation, planning, implementation, and reevaluation. Each clinical interaction has at least three cultures

involved: the service provider's culture, the culture of the person receiving services, and the culture of the system in which the person is receiving services (Wells, 1993), and everyone involved has a cultural filter (Krefting and Krefting, 1991). Since context influences functional performance, occupational therapy practitioners must consider cultural aspects during assessment phases and also when determining the feasibility and appropriateness of interventions.

This presentation, with information provided in a didactic format via overhead transparencies and slides, highlighted two case studies to compare and contrast the occupational therapy process both with and without the multicultural perspective. Presentation participants:

1. Surveyed the three dimensions of the occupational performance model according to *Uniform Terminology* III.
2. Integrated the multicultural perspective into occupational therapy theory.
3. Began to focus their cultural filters by considering cultural variations and effects on practice.
4. Developed a rationale for considering cultural diversity during the occupational therapy process.
5. Gained strategies to incorporate multiculturalism as a integral part of clinical practice.

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ADMINISTRATION/MANAGEMENT

Title

ETHICAL ISSUES IN DIVERSITY, INCLUSION, AND EQUALITY

Presenters

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Key Words

Ethics

Abstract

This workshop examines key ethical concepts in diversity, inclusion, and equality by means of case presentations and discussion. The commitment to equality and diversity presents ethical challenges for occupational therapists, who must accommodate their professional recommendations to diverse personal interpretations of human occupation congruent with individual clients' varying cultural backgrounds. Through their diverse cultural affiliations, individuals gain a sense of identify, the security of belonging, and freedom from stigma. While cultural group identification fosters inclusion of individuals, this process also creates separation, reinforces differences, and constrains individuality. Group membership thus creates ethical dilemmas involving such major values as justice, autonomy, loyalty, equality, and caring. A sound understanding of these values and their application is thus helpful in supporting occupational therapists' commitment to diversity. Careful discussion of ethical problems arising when culturally-based ethical conflicts are present can thus assist occupational therapists in improving their recommendations and practice.

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Title

Process of Development and Implementation of Critical Pathways

Presenters

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Key Words

Critical Pathways
Group Process
Task Analysis

Abstract

In today's healthcare environment, it is becoming increasingly necessary for occupational therapists to be able to identify and predict actions and outcomes over the course of treatment. Lack of ability to do this not only compromises competitiveness, but can be a major barrier to measuring quality (Olivas; Del Togno-Avmasco. et al., 1989). Properly designed critical pathways can be the mechanism for establishing outcome-based practice for improving patient and family satisfaction, for decreasing fragmentation, for operationalizing C.Q.I. at the patient care level, and very importantly, for accomodating managed care contracts (Zander, 1993).

This workshop provides occupational therapists with the knowledge and techniques needed for successful development and implementation settings. Included is an in-depth discussion of the rationale, theory, and methods for successfully moving through different stages of these processes. Guidelines and characteristics of participative management and effective teams are focal points, as is the integral role occupational therapists can play because of their unique backgrounds in group process, coping strategies, and task analysis.

Title

An Individual Outcome Approach to Services

Presenters

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Key Words

Functional Outcomes
Individualizing Services
Quality Measurement
Decision Making
Interactive Problem Solving

Abstract

The development of programs that are positive and effective at supporting personal growth is a continuing challenge for all human service professionals. Over the past two years, The Accreditation Council has developed a system of quality measurement that focuses on measuring outcomes for people. This system consists of a set of thirty outcome measures derived by The Council through discussions and interactions with people who receive services and live with various disabilities. Individual professionals and planning teams can use outcomes to direct service activities and measure success. This workshop will discuss the practical application of an outcome based performance system in the design and delivery of services.

The Accreditation Council's Outcome Based Performance Measures provide a framework for a fresh approach to services. Outcomes give service interactions a

consistent framework for professional action while allowing for individual differences in capability and preference. Individuals served are not expected to conform to predetermined performance criteria and goals. Assessing individual preferences and priorities in order to set personal goals and develop responsive services and supports is a key aspect of outcome based services. Professionals have the flexibility to design services that target individual priorities instead of external requirements. Outcomes support professionals in working with the person toward individually defined self management and personal empowerment goals.

This system of outcome based measurement will eventually replace current professional and process standards now being used for quality enhancement and accreditation. Changes in current practice to enhance emphasis on the uniqueness of each person in service and program development will be discussed. A practical approach to decision making and interactive problem solving that respects and supports individual choice will also be presented. Specific emphasis will be placed on putting these concepts to work with people who have different abilities and challenges, especially people with multiple and severe disabilities.

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Title

OT'S WANTED: EARN $90,000 PLUS!

Presenters

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Key Words

Ethics, Values, Attitudes

Abstract

The demand for occupational therapists exceeds the current supply. Within the past decade, we have witnessed an increase in the number of therapists working in private practice. The Member Data Survey and recruitment sections of our weekly publications reflect this trend. These for-profit operations typically lure therapists with glamorous offers of salary; however, they often fail to provide the basic quality assurance mechanisms that are required for ethical practice. Therapist supervision, utilization review, continuing education and research are examples of activities that are frequently neglected by these providers. Priority is directed toward boosting the bottom line. This may be accomplished by accepting therapy referrals for patients with insufficient rehabilitation potential, or billing for skilled treatments that may have been provided by an aide.

I began my research after I was "terminated" from a private therapy company. At the same time, I noticed an increased number of articles in our professional publications related to ethical concerns by members of our profession. Concerns ranged from pressures for profit and dishonest billing, to lack of supervision. After networking with members of AOTA, as well as my state association, and reviewing numerous national publications, I constructed a profile of therapists' concerns related to unethical practices within our profession.

The American Occupational Therapy Association has responded to these member concerns in several ways. A full-time Ethics Program Manager was hired in January, 1994 and is available as a resource to all members. The Office of the Inspector General, U. S. Department of Health and Human Services was contacted regarding complaints of abuse related to the Medicare System. State and national conference programs are including sessions addressing ethical concerns in our practice. As a result of my research and dialogue on this topic, the following conclusions have been reached:

> Occupational therapists must adhere to the American Occupational Therapy Association's Occupational Therapy Code of Ethics.
>
> Occupational therapists must be aware of the Core Values and Attitudes of Occupational Therapy Practice.
>
> Occupational therapists must hold a valid state license, where applicable, and follow the rules for the State Board of Occupational Therapy Education and Licensure, including the reporting of illegal, incompetent, or unethical practice.
>
> Occupational therapists must develop standard employer criteria that include consideration of the rate of and reasons for turnover; commitment to supervision and training; human resource support; and operating policies and procedures consistent with AOTA guidelines and state licensure laws, where applicable.

Title HIV Positive Care-givers - Ethical and Legal Dilemmas

Presenters

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Key Words

Acquired immunodeficiency syndrome
ethics, occupational therapy
legal issues, occupational therapy

Abstract

As AIDS becomes more common in our society, there is increasing potential that occupational therapy administrators or educators will begin to be confronted with this illness in our therapist and student populations. The possibility that an occupational therapist or student may be infected with HIV raises many ethical, legal, and emotional issues for the profession of occupational therapy.

A tragic event in Florida brought national attention and fear to the possibility of health care workers infecting their patients. A dentist with the human immunodeficiency virus (HIV) allegedly transmitted the virus to five patients (Newsweek, 1991.) The response of both professionals and the public was one of shock, prejudice, anger, fear, and confusion about the disease.

The fear and concern about HIV is mirrored among occupational therapists. In a survey of 119 occupational therapists (Atchison, Beard & Lester, 1990), 41% of the respondents feared acquired immunodeficiency syndrome (AIDS)

more than any other disease. Thirty-six percent of those surveyed feared contracting AIDS during routine care of patients with AIDS, and 36% feared transmitting the virus to their family and friends. More recently, in a survey of O.T. administrators, a large majority of respondents reported they would refuse to hire or train an HIV-positive therapist or student. (Kessler, Barnowski, Salvant, 1994).

Prior to the publicity surrounding the tragedy in Florida, the literature on HIV focused on the potential occupational hazards for health care workers. The rights of health care workers and their "right to know" the HIV status of the patient versus the patient's right to confidentiality were debated. The focus has now shifted and the debate is more reciprocal. How do we protect everyone's rights and confidentiality? This presentation will focus on answering this complex question. This presentation will address these issues within the context of the rapidly changing social, cultural and scientific environment through a didactic presentation accompanied by overhead transparencies.

Guidelines for responding to a therapist or student with positive HIV results will be proposed. Current legal references will be provided.

Upon completion of the presentation, participants will be able to:

1) Identify the dilemmas related to confidentiality, testing for HIV, discrimination and patient protection.

2) Identify the profession responsibilities of those involved.

3) Identify potential responses.

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Title

EMPLOYING FOREIGN NATIONALS: LEGAL, MANAGEMENT, CULTURAL ISSUES

Presenters

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Key Words

Cultural Diversity, Employment, Foreign Therapists, Health Personnel, International Recruitment, Management, Professional Competence, Staff Shortages

Abstract

An important occupational therapy management goal is staff recruitment and retention (7). Many foreign educated therapists now seek positions in the USA. Managers considering employment of foreign nationals should be informed regarding the multiple issues surrounding such a decision (8).

This roundtable presentation consisted of an occupational therapist employer, her attorney, who specializes in immigration law, and a foreign educated OTR employee, brought to the USA under the attorney's guidance (3). They presented their perspectives regarding employment of foreign nationals and the implications such employment has for culturally relevant occupational therapy practice.

To hire foreign nationals, employers must follow strict federal and state rules and regulations. Legal guidance is important in order for managers to understand the roles of the federal and state departments of labor, U.S. Immigration and Naturalization Service, and U.S. embassies. These agencies have oversight in the processing of applications and monitoring of foreign therapists. Current policy considerations (2) and relevant legislation must also be considered when hiring.

Employers must be aware of multiple management issues, including: fees; travel to the USA; temporary housing; work documents; orientation and on-site training; and accommodating for "culture shock". Both the employer and foreign therapist must be aware of pre-and post-employment concerns. This may include such issues as: unfamiliar terminology and procedures in practice settings; differences in role delineation concerning occupational therapy and other team members; clarity in verbal and written communication; and technological advances that may not have been available in the therapist's country. The importance of supportive employers who are forthright and clear in regard to supervision, licensure, and environmental issues was stressed, as were the multiple adjustments required in a new culture.

Culturally diverse occupational therapy teams may enhance service delivery by expanding team member knowledge and skills, and helping therapists become aware of their cultural biases (1,4,6,9). This heightened awareness will help therapists consider each individual's unique cultural identity as it applies to occupational performance, thus enhancing their assessment and intervention strategies (5).

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Title

MANAGING THE THREE R'S:
Recruitment, Retention, and Reactivation

Presenters

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Key Words

Recruitment
Retention
Reactivation

Abstract

With the current shortage of occupational therapists, administrators must turn to alternative strategies of recruitment and retention.

This presentation is divided into three themes: recruitment, retention, and reactivation. In addition to discussing the impact and implications of these themes on occupational therapy personnel, a broader perspective on all rehab personnel will also be addressed.

The Recruitment section will not only discuss current shortages, but techniques used to entice people to enter the field. Recruitment strategies to entice staff will be highlighted through a discussion of traditional methods and alternative strategies.

The Retention section will have two parts. First, a review of current literature in occupational therapy and other rehab fields will be presented with regards to attrition and

retention issues.

Secondly, studies will be presented based on recruitment and retention issues in acute care and long term care settings. A focus on tool modification will enable therapy managers to discuss specific issues within their respective work environments.

Finally, reactivation will be explored. Results of the grant awarded from AOTA to MOTA will be discussed. Resources available to reactivating therapists and their supervisors will be presented. Perceptions will be shared from both the reactivator and supervisor perspectives. An on-site reactivation program will be reviewed.

Administrators and managers should leave the workshop with a knowledge of issues currently affecting therapists recruitment and retention decisions. Furthermore, they will be able to return to their own work sites and evaluate issues directly affecting their employees through a systematic research design. Finally, managers can determine whether the impact of an on-site reactivation program is appropriate, and its possible effect on their employees and staffing patterns.

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Title

Administration/Management SIS Program: The Numbers Game—Students, Profits, and Reasoning

Presenters

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Key Words

Fieldwork
Clinical Reasoning
Health Care

Abstract

The most recent Occupational Therapy education essentials support the value of promoting clinical reasoning and reflective practice during fieldwork (AOTA, 1991.) The rapidly changing health care climate has forced fieldwork supervisors to focus much of their attention on productivity and fiscal concerns. These conflicting forces have created greater challenges for fieldwork educators. How do we design education programs that inculcate professional values of reflecting on practice while preparing students to function effectively as professionals in their complex fieldwork settings and beyond? The current environment presents a challenge to all those involved with professional education and service delivery; administrators, managers, clinical supervisors and educators.

A panel of representatives from research, practice and education addressed the following perspectives:

> An occupational therapist researcher with a background in administration and practice reviewed the role of practice context in clinical reasoning. The influence of service site, caseload and equipment on treatment choices was discussed.
>
> The linkage between the ideals and values taught in the academic setting and the realities of current clinical practice were explored from a student's perspective.
>
> Collaborative learning, a form of indirect teaching in which the instructor states the problem and organizes the students to work it out in peer groups was presented as one alternative approach to address this challenge.

A lively audience discussion explored other solutions to facilitating clinical reasoning and providing effective fieldwork experiences in today's reimbursement and productivity driven health care environment.

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Title

Physical and Occupational Therapy: Friends or Foes

Presenters

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Key Words

physical therapy, occupational therapy, interpersonal relationships

Abstract

Physical and occupational therapy have been linked together in the theory and treatment of physical and developmental disabilities since the early thirties. In a market driven economy, competition and cooperation require a comprehensive knowledge of those who can deter and facilitate and practice of occupational therapy. Knowledge of how physical therpy is alike and dissimilar to occupational therapy increase the decision making power of practitioners as to when and how to improve working relations with physical therapists. Such knowledge also strengthens the option to market occupational therapy separate from physical therapy if and when needed.

Physical therapy practice can be both a detractor from and facilitator toward occupational therapy practice. To decide when physical therapy is a friend or foe, occupational therapyists need to know the strengths and weaknesses, and comparisons and contrasts of physical therapy in the health care delivery and educational environments. For example, how much alike are the fields in philosophical view, theoretical development and models of practice? Who wanted and still wants to combine the two fields? In what situations can the two fields work together sucessfully? Would cross training work? This presentation will review the historical background and current trends of the two fields.

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Title

DEALING WITH CONFLICT: GETTING TO "YES"

Presenters

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Key Words

Conflict Resolution
Negotiation
Management

Abstract

With the changing health care environment, undue conflict can often erupt. If not resolved, it can evolve into a source of stress and discomfort for staff and managers. Therefore, it is essential for effective occupational therapy managers to be able to efficiently identify and resolve conflict situations.

The presentation will include a discussion of predisposition to conflict and both the positive and negative results of conflict. Furthermore, stages of conflict and steps for effective management of conflict will be presented. Strategies for resolving conflict with "difficult types of people" will also be discussed. An instrument for identifying participants, specific conflict management style will be provided. Additionally, a conflict questionnaire will be circulated for participants effective use on managing conflict within their work environments.

The difference between conflict resolution and negotiation will be highlighted with the principles, strategies and techniques of negotiation discussed. An opportunity to role play a negotiation process will be included to encourage participants' interaction.

At the conclusion of this workshop, therapy managers should be able to feel comfortable identifying stages of conflict and negotiation, identifying when each of these processes should be used, and integrating principles learned from these exercises when returning to their changing work environment.

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EDUCATION

Title

Preparing Students and Therapists for Culturally Appropriate Service Delivery

Presenters

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Key Words

Multicultural, Education, Cross-cultural competence

Abstract

On other side

"Like a rich quilt in colors, textures, and patterns, the United States is a nation made up of many ethnic, racial, religious, and cultural groups" (Randall-David, 1989 p. 1). Culture is a learned, shared, and a symbolically transmitted design for living. The United States has become a pluralistic, multicultural society which is requiring occupational therapists to effectively work with and value human diversity. Within many clinical settings, therapists are faced with issues of cultural diversity daily.

So how can occupational therapists develop skills in cross-cultural competence? The development of these skills first require occupational therapists to identify and examine their own cultural attitudes, beliefs, values and behaviors. Therapists resist *ethnocentrism* (the belief that one's own cultural values and behaviors are the only correct one) and develop *cultural relativism* (the perspective that one can best understand a person's cultural beliefs, values, and behaviors in the context of that person's culture, not one's own). Therefore, therapists need to stop evaluating a client in the context of the therapist's environment and instead expand their views to consider the various multicultural factors affecting a client and his or her family. Therapists also need to be careful not to confuse scientifically based practices with their own cultural understanding.

Chrisman (1991) presents three basic principles of culture-sensitive care (when culture is **always** taken into account in the process of aiding client's to achieve optimal health). These three principles: knowledge, mutual respect, and negotiation are a framework that can used within clinical and educational settings to effectively address cultural diversity. ***Knowledge*** is what is known about the client, family, community, behavior and disability. Occupational therapists gather this information from a variety of sources. These may include: 1) personal experience; 2) client and family (including friends/acquaintances from the individual's and family's culture); and 3) literature. ***Mutual Respect*** is working with rather than on a client or family. This is the key to developing a therapeutic relationship. It requires communication, openness, and creativity. Finally, ***negotiation*** is used when an impasse has occurred. The goal of negotiation is to optimize client outcomes and at the same time support the occupational therapist's technical and ethical concerns. A therapist will not be able to be compromise through negotiation if he or she has not first gathered any needed knowledge and developed a therapeutic relationship based on mutual respect.

Thus, preservice and inservice training is needed to enable occupational therapists to develop a sensitivity to their own culture, knowledge about another's culture, and skills in selecting and utilizing culturally sensitive intervention techniques. No matter where a therapist is working along the continuum of early intervention to geriatrics, collaborative relationships between professionals and families of diverse backgrounds may help to enhance and improve the therapeutic relationship during treatment.

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Title

CRISP: A Method for Increasing Awareness of Clinical Reasoning

Presenters

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Key Words

clinical competence, education

Abstract

CRISP, an acronym for "clinical reasoning interacting with service provision" describes a group-consensus method for reflecting on day-to-day practice. Unique to CRISP is the development of "templates" to assist practitioners in identifying frames of reference, perceptions of illness, cultural biases, or emotional blocks hidden below the surface. Because CRISP begins with the learner's own experience it provides an innovative and exciting way to explore steps and blocks to specific treatment decisions.

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Title

Orthotic Education: Teaching Students Critical Thinking

Presenters

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Key Words

Critical Thinking, Orthotics, Education

Abstract

Recently, there has been a number of studies on clinical reasoning. Studies conducted by Fleming, Mattingly, and Gillette (1994) focused not only on how therapists think when treating patients, but also about what therapists think about their practice. In 1983, Rogers and the Entry-Level Study COmmittee Report (AOTA, 1987), emphasized the need for students to be critical thinkers. Teaching a student how to choose and fabricate an orthosis involves a knowledge base of occupational therapy theory, and a basic science background of pathology, kinesiology, anatomy, physics, and physiology (Hunter, Schneider, Macklin, Callahan, 1990). It also requires the student to utilize the process of critical thinking in solving complex problems. Critical thinking skills are required to analyze hand dysfunction, make suggestions for splinting needs, evaluate splint performance, and teach the patient proper care and use of the splint.

As occupational therapy program faculty members and clinical educators, the skill of critical thinking should be taught in conjunction with orthotic fabrication skills. Critical thinking processes have been taught at Creighton University in the orthotics section for the past three years.

This presentation will expose the participants to methods of providing educational experiences to students that involve critical thinking in the context of orthotics education. Following the presentation, the participant will be able to: 1) understand the importance of teaching critical thinking skills in orthotic education; 2) give examples of educational activities including laboratory exercises, self and instructor evaluations, case studies, splint analyses; 3) identify educational activities for students with different learning styles.

Title

Confessions To An Urban University Fieldwork Coordinator

Presenters

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Key Words

cultural diversity, fieldwork experiences, sensitive situations

Abstract

Some fieldwork students periodically have attitudinal or performance problems when sent to ethnic or cultural environments that differ from their own. A round table discussion format is used to examine and explore resolutions to these sensitive situations.

The discussion is divided into three segments that begins with exploring ones own beliefs, then moves to sharing sensitive experiences and concludes with addressing preventative strategies. The first segment will provide an opportunity for participants to explore their biases, attitudes and fears about different ethnic or cultural groups. Self assessment exercises used for this segment will be adapted from exercises found in, Developing Multicultural Competency, An Education and Resource Manual for Educators and Practitioners, by Shirley Wells, the American Occupational Therapy Association's Minority Affairs Program Manager.

Following interaction from these exercises, actual experiences encountered by the presenter and participants will serve as catalysts for further discussion. Examples include, African American students being mistaken for janitorial staff by suburban hospital personnel and Caucasian

students entering an inner city elementary schools and being overwhelmed by " a sea of black faces". These and other encounters will be analyzed with the goal of finding various approaches to dealing with similar situations.

The closing segment will address practical strategies for clinical student supervisors and academic fieldwork coordinators to use to prevent or soften the impact should such situations arise in the future.

Title

Strategies for Better Instruction in Occupational Therapy

Presenters

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Key Words

Education
Objectives

Abstract

With the aging of the population and changes in the health care environment, the shortage of occupational therapists has become more acute than ever. To address this problem, more educational programs in occupational therapy have been started or are being planned and established programs are increasing their enrollment (Educational Data Survey, 1993). Unfortunately, this has caused a acute shortage of qualified faculty members to develop, chair, and teach in these new and/or expanding programs (e.g., fifty-one vacancies were reported at the professional level in 1992, (Educational Data Survey, 1993) . Although clinically based occupational therapists being recruited to teach courses or become full-time faculty are wonderful additions to programs because they are practiced focused, they often lack the knowledge of how to "teach" in a traditional educational setting. Specifically, new faculty do not know the mechanics of developing a syllabus, writing specific objectives that can be then translated into exam questions, or writing an exam that can be objectively scored. (Only 4.3% of occupational therapists have an educational background or educational certificate (Member Survey Data, 1990).

Therefore, the purpose of this workshop is to present and practice these needed skills for new full-time or part-time faculty. Specifically, the goal of this workshop would be to help participants: 1) develop a course syllabus that incorporates all the necessary elements, 2) write specific objectives based on the taxonomy of educational objectives, and 3) write an exam with well-constructed questions that are based on the course's instructional objectives.

In addition to the necessary elements of syllabus writing being presented, this will be a "participatory" workshop in which participants will be presented a model syllabi with guidelines for implementation and then encouraged to write objectives for course materials they are teaching. Presenters will discuss general guidelines for developing exams, offer specific examples of well constructed test items, and give appropriate feedback to participants' attempts at test writing.

The presenters will share their experiential knowledge regarding writing course syllabi and exams, developing appropriate assignments with grading criteria, and correlating these with course objectives. Examples will be provided to illustrate the points discussed. Finally, techniques of how to facilitate learning in today's multicultural environment and how to enhance the teaching-learning process with students from diverse backgrounds will be discussed.

In sum, this workshop will be a program session designed specifically for new (even "old" faculty) who have not have the luxury of being "taught" the educational techniques and skills they need in order to be good instructors.

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1990 Member Survey Data.. Research Information and Evaluation Department, American Occupational Therapy Association, Inc.

1993 Educational Data Survey Final Report. Research Information and Evaluation Department, American Occupational Therapy Association, Inc.

Title

Establishing Multicultural Competence: Comparison of Two Educational Models

Presenters

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Key Words

culture; education, occupational therapy; practice

Abstract

In 1991 the Essentials and Guidelines for occupational therapy educational programs were revised to require course content related to collaboration and the effect of sociocultural factors on occupational therapy (OT) practice. Specifically, programs were mandated to include "...human adaptation and life satisfaction across the life span, including a multicultural perspective", "human behavior in the context of sociocultural systems...", and "collaboration with patients, caregivers, COTAS, and other professionals" (American Occupational Therapy Association, 1991, p.1081). Because these requirements have only recently been implemented in OT education, most therapists cannot be expected to demonstrate multicultural competence in their OT practice, particularly as it relates to performance of activities of daily living (ADL). The authors of this presentation have implemented two different educational models for establishing multicultural competence. The programs, both in private universities, are of two different formats: an intensive three day seminar with later followup activities,

and a semester long course. While developed for use in occupational therapy curricula, these models have relevance for staff development.

Cross cultural competence as it applies to occupational therapy implies that therapists have skills in collaboration, oral communication, and problem solving abilities, in addition to culture specific information. Cultural competence is particularly important in addressing client concerns about performance of activities of daily living, since role performance, activities, and maintenance of the home environment are in particular strongly influenced by sociocultural factors. Therapists unfamiliar with the cultural backgrounds of their clients may be less than effective in setting meaningful and relevant treatment goals. Given that therapists cannot be expected to be conversant in all cultures, it is imperative that exploration of culture be included systematically in both occupational therapy education and treatment planning.

The purpose of this workshop is to (a) compare and contrast two educational models for preparing OT students for multicultural competence; (b) apply these models to staff development of experienced occupational therapists. This three hour presentation will utilize a combination of lecture, experiential learning activities, and review of audiovisual materials.

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Title

"A Sense of Place"—Level 1 Fieldwork in Appalachia

Presenters

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Key Words

Fieldwork, Occupational Therapy, Level I
Education, Occupational Therapy
Rural Population

Abstract

Over a four-year period, from 1991 to the present, a select group of occupational therapy students at Eastern Kentucky University (EKU), have been traveling to the Appalachian mountains of Kentucky in order to learn basic professional skills in a culture usually very different from their own. Level I fieldwork at EKU provides the framework for innovative fieldwork experiences, using faculty as academic supervisors in many non-traditional sites. Faculty are encouraged to develop new fieldwork sites at agencies without therapists, and organize and lead the students in service provision. With the assistance of a Rural Health Grant, a new fieldwork experience was developed for an area of the University's service region, namely Appalachia.

The hills of Eastern Kentucky are an area of this country that has very few occupational therapists. The uniqueness of the Appalachian region, and the inhabitant's "sense of place" as described by Blakeney (1987), provided this group of students with a beginning understanding of these communities in need of occupational therapy service. An essential ingredient of the educational experience was for students to live in, and become involved in, the community of Hazard, Kentucky. In this way the people of the mountains could be understood not only from their health care needs, but their culture, economics, and geography.

Previous impressions of the Appalachian region and its people were obtained from each group of students at the beginning of their Level I fieldwork experience. At the end of the experience the reactions of the OT students, as well as the community agencies, was documented as a means of evaluation. It was most interesting to note that an unknown area of the Commonwealth of Kentucky became known as a reality as opposed to its myths, and that students could overcome misconceptions of people and places to see the challenges and joys of providing occupational therapy..."in these hills". The words of James Still (1986), a poet and writer of the mountains who speaks eloquently of mountain people's sense of place, could then be understood: "Being of these hills I cannot pass beyond."

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Title

NEW FACES: CHANGING DEMOGRAPHICS OF OCCUPATIONAL THERAPY ADMISSIONS

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Key Words

Education - Occupational Therapy
School Admission Criteria

Abstract

PURPOSE OF STUDY

Recent changes in demographics, as well as reconsideration of admissions testing in higher education and issues related to evaluation of minority applicants (1) prompted an interest in conducting a national survey to evaluate admission criteria, procedures and demographics for six allied health professions including occupational therapy.

METHOD

Survey items addressed: general program information, prerequisites, admissions criteria and procedures, applicant demographic information. Directors of all professional level educational programs were surveyed in 1992 (n=80). Data analysis used SPSS to calculate frequency distributions. The literature review included allied health admissions, minority recruitment and retention (2-3).

RESULTS

General Program Information

The response rate was 95%. Institutions were 70% public and 30%private. Ninety percent offered full time study with 94% of the classes during the day. Part time study was an option for 19%. The mean class size was 40.

Program Prerequisites and Admission Criteria

The most commonly required prerequisites were: anatomy and physiology, physics, chemistry, biology and psychology. The most frequently utilized admission criteria were: college GPA (87%), references (61%), writing sample (55%), science GPA (50%) and interview (46%). Standardized test were rarely required: SAT (20%), GRE (18.4%), TOEFL (14.5%), and AHPAT (3%). One third of the programs required volunteer work (mean of 40 hours). The five most important prerequisite characteristics were communication skills (written, oral and interpersonal), academics, motivation, work/study skills and problem solving/creativity.

Admission Procedures

In 74% of programs, faculty participated in the admissions process, 53% also reported involvement of the admissions office. Most frequent responsibilities were: interviews, post-admission counseling, review of documents, faculty follow-up discussion and final decision making. Strengths of the admissions procedures were its objectivity and the value of the interview, although the admissions process was time-consuming.

Applicant Demographic Information

The applicant pool had increased. Five years prior 83% of programs had 20 to 100 applicants, whereas recently only 30% were in this range. Currently 40% of the programs had a pool of 101-200 applicants. Increases were reported for older applicants (74%), second-career applicants (70%), ethnically diverse (37%), disabled/challenged (36%) and part time students (24%). Younger applicants decreased in 23% of programs. Categories of students remaining the same were: full time (55%), international (49%), disabled/challenged (43%).

IMPLICATIONS

Admissions committees must meet the challenge of selecting qualified students reflective of the diversity inherent in the multicultural populations that they are committed to serve. A further consideration is research indicating that traditional admissions measures relying primarily on grades and standardized tests decrease the acceptance rates of minority students (1). With the changing demographics of the allied health applicant pool and greater demands for educational and health care accountability, academic programs must evaluate the efficacy and appropriateness of admissions criteria and procedures.

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Title

A partnership model: Integrating academic and clinical cultures.

Presenters

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Key Words

Faculty Practice, Clinical Faculty, Clincal Practice.

Abstract

Academic (university based) and clinical (hospital/community based) faculty cultures traditionally have been separated due to different role definitions and sets of criteria for promotion. The overall goal of this paper is to describe the successful experiences of two doctoral-trained faculty in the integration of their diverse roles. One author is a clinical non-tenure track associate professor whose major responsibilities are as the director of occupational therapy at a university-affiliated community re-entry program. The other author is a tenure-track assistant professor whose major role functions are teaching and research. The authors propose a partnership model for faculty practice as a way of incorporating practice into the academic faculty role and teaching/research into a clinical faculty role. An analysis of the differences between clinical and academic faculty roles and the benefits and potential difficulties with a partnership model will be discussed.

This is an important issue for occupational therapy as new doctoral level educational programs are being developed. Traditional PhD programs emphasize preparing doctoral students for academic roles. However, with the projected changes in the health care system, occupational therapy needs to prepare clinical and academic leaders who are both scholars in occupational science and experts in applying the science. Defining the role of doctoral-trained faculty in practice is currently being addressed by other health professions, especially nursing (Wright, 1993; Lambert & Lambert, 1988; Bibace & Walsh, 1982). A review of this literature will be presented.

The method of presentation will be a lecture format with slides. The authors will provide handouts with references.

By the end of the presentation participants should be able to:

- compare and contrast a faculty and a clinical faculty role in a specific university setting.
- describe a model for integrating these diverse roles and cultures.
- discuss the advantages and disadvantages of the partnership model.
- identify these issues as they relate to other health professions.
- extend the application to their own setting.

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Title

Sexual Orientation and OT Education:
Recognizing & Overcoming Barriers

Presenters

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Key Words

Education, Occupational Therapy; Minority Groups; Homosexuality

Abstract

The field of occupational therapy has recognized the importance of cultural diversity and the increasing need to address cultural diversity in its educational programs. Adrienne Vilaubi, OTR, has stated, "We must insist that our educational and professional institutions incorporate appreciation for cultural differences and diversity training in their programs" (Vilaubi, 1992).

One area of cultural diversity which has received little attention in the teaching, learning, and practice of occupational therapy is that of gay and lesbian culture. The presence of a lesbian and gay culture has been recognized by social scientists, educators, and occupational therapists (Banks, 1992; Dillard, Andonian, Flores, Lai, MacRae, & Shakir, 1992), but there has been little examination of this culture in the context of occupational therapy education. Examination of diversity causes us to confront and question our commonly held assumptions and internalized principles

(Tierney, 1992), bringing our communication--and our learning--to a more meaningful level.

A survey conducted by the authors revealed that some of the experiences and needs of gay and lesbian students differ from those of heterosexual students--which is congruent with the current literature (Andreas, Berrill, Knefelkamp, Obear & Washington, 1992; Geller, 1990; LaSalle, 1992; McNaron, 1991).

This roundtable will include a summary of the survey results and implications, identify ways to support gay and lesbian OT students during the educational process, and encourage suggestions for increasing awareness of cultural issues related to sexual orientation for all students. Research on academic climates reports that individuals are most effective when they are able to study and work in an organization where they feel appreciated and affirmed (Tierney, 1992).

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Title

MENTORING MINORITIES INTO ACADEMIA: A Model for Practice

Presenters

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Key Words

Education, Mentors, Minorities

Abstract

A domain of occupational therapy that receives less attention than others in the selection of a practice area is that of education. Recent survey information released from AOTA in a 1993 report revealed an overall shortage of occupational therapists in the practice area of education at both the technical and the professional level. Even more unsettling, the AOTA survey also revealed an even greater shortage of ethnic minorities in education. The survey data revealed that 10.3% of faculty on the technical level and 9.9% at the professional level were ethnic minorities (S. A. Wells, personal communication, February 28, 1994). With an existing pool of qualified occupational therapists, identifying the reason behind the non-selection of academia as a career choice and developing an approach to resolving the dilemma is a challenge for the membership and the Association. Factors that seem to contribute to the disparity are the absence of formal or structured training in the education process for new

O.T. educators, as well as the current shortage of minority occupational therapy educators in the classroom. Minority educators serve as role models to further influence the practice choice of minority students enrolled in an C.T. curriculum. To compound the existing problem, there is growing concern about the percentage of occupational therapy educators who are returning to the clinical practice.

A dynamic mentor-protégé relationship can provides a means for the transfer of knowledge, skills, attitudes, and aspirations. It contributes to the personal and professional development of both parties, and ultimately to the growth of the profession as a whole.

This presentation introduced a mentor-protégé model designed: (a) to encourage minorities to consider and perhaps select academia as their practice area of choice, (b) to encourage the experienced occupational therapy educator to engage in a mentor-protégé relationship in response to the intense faculty shortage that exist among minorities and © to provide the would-be educator with information on exploring potential positions in academia.

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Title

The Clinical Reasoning Journey: Asking Effective Questions

Presenters

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Key Words

- clinical competence
- education, occupational therapy, teaching methods
- fieldwork education, occupational therapy, teaching methods

Abstract

The Clinical Reasoning Journey: Asking Effective Questions

Clinical reasoning, defined by Fleming (1993) as being "the many types of inquiry that an occupational therapist uses to understand patients and their difficulties" (p. 870) has received increasing attention in the past few years. Research has begun to identify that the experienced therapist uses multiple thinking strategies which appear to develop over time (Mattingly and Fleming, 1994).

Although clinical reasoning matures with an array of experiences, educators and fieldwork supervisors can improve a student's clinical reasoning through the use of appropriate teaching techniques. Cohn (1989) has suggested several strategies to encourage the development of clinical reasoning in the fieldwork student. One of these strategies is questions, which is clearly identified as one of the primary teaching techniques (Cohn & Czycholl, 1991). Questions may also be inherent in other teaching strategies.

Because the use of questions is the most common teaching technique employed (Clegg, 1987), integrating information on questioning strategies from the educational

literature can provide specific guidelines for using questions to promote clinical reasoning. A classification system of questions was presented in order to allow differentiation between a lower level and a higher level of thinking (Bedwell, Hunt, Touzel and Wiseman, 1991). Strategies such as timing, clear phasing and modification of the question were identified as techniques to promote the effective use of questions (Dantonio, 1990).

A review of clinical reasoning provided an overview of the developmental stages of students' thinking skills (Affeldt, 1994) in order that participants could begin matching questions to a student's current reasoning abilities. It was demonstrated that effective questioning is not only identifying a single question but is a dynamic process of sequencing a series of questions to facilitate the development of clinical reasoning.

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Title **An Innovative Approach To Teaching Assistive Technology**

Presenters

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Key Words

assistive technology
education
computer-assisted instruction

Abstract

The American Occupational Therapy Association (AOTA) has targeted the attainment of knowledge and skills in assistive technology as a priority in the 1990-1995 national strategic plan. However, many preservice undergraduate programs do not have technology training or have the resources or expertise on their faculty to provide these experiences (Kanny, Anson, and Smith, 1992). In 1993 the Technology Special Interest Section (TSIS) of AOTA drafted foundation level technology competencies for preservice training programs (Hammel and Smith, 1993). These competencies at the foundation level also would apply to practicing therapists. Although practicing therapists recognize the need to understand and apply assistive technology, they do not have these skills and knowledge (Pritzlaff and Smith, 1989). "Therapists who have been practicing for a number of years should also consider themselves deficient in these competencies and should seek resources to acquire them through inservice continuing education" (Hammel and Smith, 1993, p. 975).

Occupational therapists, who are entering the profession or are already in practice and have not had the opportunity to learn about assistive technology possibilities, are limited in their ability to apply assistive technology to the needs of individuals with disabilities. Although traditional approaches, such as continuing education workshops, are beneficial to therapists who have access to them, many therapists do not have the time, money, or convenience of location to attend these educational opportunities. An interactive computer program can address both the critical need for information and the problem of convenient access for

practicing therapists. It enables them to acquire knowledge and skills in an accessible manner and at a comfortable pace. An interactive computer program could also provide a constant source of information for "new" employees in the event that a knowledgeable therapist leaves the facility.

Project ASTECH is a 4 year special project funded by the Department of Education. It includes a multimedia, interactive CD-ROM computer program that uses text, digitized voice, pictures, graphics, animation, review questions, and quick time video clips to present information about adapted computer access, augmentative communication, and environmental control. Therapists can use it individually or with other members of their own provision team. A printed resource guide gives supplementary information.

When practicing therapists and new graduates have knowledge about assistive technology, they can create more effective programs which enable individuals with physical disabilities to perform more independently in a variety of contexts. Using an interactive computer program is an innovative approach to learning this information.

Acknowledgment

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Title

Innovative Teaching Method: Interactive Multimedia Computer Assisted Instruction

Presenters

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Key Words

Computer-assisted instruction, computer, technology, interactive multimedia, education, teaching method.

Abstract

This paper describes the application of an innovative teaching method for occupational therapy educators. Smart educators and curriculum planners have already started to explore the application of interactive multimedia computer technology -- to prepare for what appears to be tomorrow's teaching techniques. Information related to hardware requirements, the technical development of interactive multimedia CAI teaching module, and the clinical application for patient education will be discussed. Open discussion with participants will allow them to share their experiences in using interactive multimedia CAI .

Paper Title: Innovative Teaching Method: Interactive Multimedia Computer-Assisted Instruction

Incorporation of computer technology into higher education is no longer a luxury; it is now considered a necessity. With the pressure of increasing student enrollment, without concomitant increase in faculty and budget allocations, the occupational therapy educator looks for ways to maximize the student's learning experience in the face of large student-to-faculty ratios. The successful application of modern technology of computer-assisted instruction will substantially reduce classroom contact hours for the majority of students, and thereby free the instructor to spend time with a diverse population of students who need more individual attention. Educators in the health professions have used computer-assisted instruction (CAI) since the 1960s. This of type computer-based tutorial design has been found to improve occupational therapy student's interaction with the subject matter, materials, and teacher.

The "old idea" of an effective CAI technique is being further enhanced with today's modern computer technology -- interactive multimedia. The most advanced multimedia productions involve using animation sequences to illustrate complex concepts. The interactive features allow the student to use the computer to interact with concepts and procedures, setting an individual pace and branching to different topics and areas as they are of interest.

At Texas Woman's University (TWU) in Houston, Texas, with the state-of-art interactive multimedia program (Animated Dissection of Anatomy for Medicine), the instructor can apply this modern technology in teaching occupational therapy students. The student can be guided through learning experiences such as the anatomical database. The authoring tools will enable the occupational therapy instructor to organize material for teaching and training by attaching notes, animation, and video in side screens. Information related to hardware requirements, the technical development of interactive multimedia CAI teaching module, and the clinical application for patient education will be discussed in this paper. Open discussion with participants will allow them to share their experiences in using interactive multimedia CAI.

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Title

Dynamic Systems Theory: Women, HIV/AIDS, and Occupation

Presenters

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Key Words

Acquired Immunodeficiency Syndrome, Systems Theory, Women's Rights

Abstract

The rate of AIDS reported in women is increasing more rapidly than in men (CDC, 1993). The reasons for this are a complex pattern emerging out of a dynamic system of interrelated systems of biology, politics, gender relations, race, class, and social status based on ethnicity and HIV status.

Nonlinear dynamical systems theory (DST) (Kellert, 1993; Scholz, 1990) (DST) can be used to view health and illness not as dichotomies, but rather as complex patterns. Applied to the health of women with HIV/AIDS, DST can be used to describe relationships between occupation and health not adequately addressed by hierarchical system models (Clark, Parham, Carlson, Frank, Jackson, Pierce, Wolfe, & Zemke, 1991; Keilhofner & Burke, 1980) in occupational therapy literature.

The occupations of women influence health status through a dynamic pattern of complex interactions with micro-level pathogens and macro-level systems of health care, culture, and economics. Principles of DST (Thelen & Ulrich, 1991) address how these interactions may occur. Attractor states, as self organizing patterns of activity, can be shallow (easy to change) or deep (more difficult to change) attractor wells. Order parameters, (eg. occupational function) are variables which express the orderliness of degrees of freedom available in the system. Control parameters are variables which are the source of potential change in a system. When a control variable is identified and manipulated it can create a shift in a pattern (eg. function). A DST approach to treatment might suggest that treatment should create a phase shift in the pattern of health and occupation by focusing on control variables and shallow attractor wells. Evaluation would then focus on identifying order parameters, potential control variables and shallow attractor wells.

The theoretical framework of Black feminists (Collins, 1990; Combahee River Collective, 1984; King, 1988) is brought into this discussion because of its potential compatibility with DST in looking at intersecting relationships between social and environmental factors of race, class and gender in the production of occupation and health and because HIV/AIDS has disproportionately taken its toll on Black women world wide.

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Title

APPLICATION OF DYNAMIC SYSTEMS THEORY TO HUMAN OCCUPATION

Presenters

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Key Words

Occupational Science
Human Occupation
Systems Theory

Abstract

Dynamic systems theory arose from physics and applies to systems which display a "remarkably rich and subtle diversity of behavior" (Davies, 1988, p.25). A study of dynamic systems theory reveals an evolutionary process that is changing the meaning of science and the notion of complexity. Experts believe this "conceptual revolution" may represent a convergence of science and the humanities (Prigogine & Stengers, 1984). Through its rich, scientific background and evolution, dynamic systems theory offers support and validation to a science aimed at understanding human occupational behavior.

Occupational science pioneers inform us that, because occupational science aims to illuminate such a complex phenomena from a non-reductionistic view of human activity and health, it must be abstract at the conceptual level (Yerxa et al., 1990). We must reject dualism and search for scientific knowledge which supports the complex nature of the human as an occupational being (Zemke, 1994). Outside of its application in physics, dynamic systems theory has been used as a model to explain behavior in other complex systems such as motor development and cognitive and language growth (Kamm, et al., 1990; van Geert, 1991). This paper will explore the application of dynamic systems theory to the study of the human as an occupational being.

On the macroscopic level, dynamic systems theory supports the need for examination of complex systems on multiple levels and represents the contemporary scientific mode of studying such systems. Dynamic systems theory may offer a tool for conceptualizing the processes involved in the emergence of human activity patterms, or adaptation through occupation. General concepts demonstrating the relevance of dynamic systems theory to occupational science as well as its application in other fields will be mentioned.

On a microscopic level, several principles basic to dynamic systems theory may provide clarity and conceptual depth in understanding the complex nature of the human as an occupational being. Clients in occupational therapy represent a nesting of multiple dynamic systems. The main tenets of dynamic systems theory will be explored in relation to concepts such as human occupation, adaptation, choice and temporality.

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Title

TEACHING CLINICAL REASONING AND TREATMENT PLANNING USING OTFACT

Presenters

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Key Words

Technology Education Occupational Therapy

Abstract

Formulating a treatment plan and the clinical reasoning that accompanies this process are an integral part of occupational therapy curricula. Treatment planning is a process of evaluating and synthesizing data into a coherent whole that reflects individual needs for remediation in role performance, occupational performance, and performance components as well as strengths, interests, goals, and valued roles. The analysis and synthesis skills associated with this process are described as higher level thinking skills (Gronlund, 1991, p. 45) and represent a formidable task for students. The question becomes how to facilitate and support this process.

Educators typically use some form of case study to teach clinical reasoning and treatment planning; however, there is little published information related to this process. Neistadt (1987, 1991) has published two studies describing the use of in-class evaluations to lead students through a clinical reasoning process.

Another promising approach is OT FACT, a computerized instrument for collecting, integrating, and reporting assessment data (Smith, 1990). A major problem identified by academic and fieldwork educators is the difficulty students have moving evaluation findings

academic and fieldwork educators is the difficulty students have moving evaluation findings into a treatment plan. OT FACT provides a taxonomy for data entry that includes 213 categories reflecting all major practice areas and settings (Smith, 1990). It quantifies the data to reflect individual strengths, weaknesses and progress and provides prompting questions to lead users through a clinical reasoning process.

Another problem for students is developing treatment goals reflecting the interrelationships between role performance, occupational performance, and the performance components. The functional performance categories of OT FACT require students to enter evaluation data in a manner that considers this hierarchical relationship.

This presentation will describe how OT FACT has been used in academic and fieldwork settings, cases developed for OT FACT and student treatment plans, and faculty and student perceptions of the value of OT FACT in developing treatment planning and clinical reasoning skills.

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Title

Understanding Human Diversity Through Innovative Fieldwork Education

Presenters

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Key Words

FIELDWORK EDUCATIONS, OCCUPATIONAL THERAPY
STUDENTS, OCCUPATIONAL THERAPY
PSYCHOSOCIAL ASPECTS OF ILLNESS
CULTURE (SOCIOLOGY)
SEMINARS & WORKSHOPS

Abstract

Occupational Therapists face many challenges as society approaches the twenty-first century. One challenge is to empirically define the nature of occupational dysfunction and the role of occupational therapy in ameliorating dysfunction (Gilfoyle, 1988; Royeen, 1988). Although research has been identified as a vitally important activity for occupational therapists, few therapists actively engage in clinical research (Gilfoyle, 1988; Gibson, 1984). Another challenge facing occupational therapists is to develop an understanding of gender and cultural differences (Dillard et al, 1992) and to treat increasing numbers of patients who have high risk communicable diseases and/or terminal illness. The diverse nature of patients' backgrounds (ethnic, cultural, and gender orientation) may present a barrier to efficacious patient assessment (Evans, 1992). In order to provide "effective...(services which are) caring and respectful of the patient" (Accreditation Manual for Hospitals, p. 51, 1994), therapists must develop an awareness of their own personal biases and be sensitized to relevant differences between themselves and their patients (Gaw, 1993). Innovative fieldwork education programs in a wide variety of settings are

needed to prepare students to face such challenges. However the design and implementation of such fieldwork programs has been limited (Opacich, 1990).

The National Institutes of Health (NIH) has designed a fieldwork education program which provides an opportunity outside academia for students to learn clinical research skills while working with patients with very diverse backgrounds and needs. At NIH, clinical research and clinical practice are intertwined in a single system that offers unique learning opportunities for student therapists. Students also participate in training activities which address caregiver issues, particularly those related to terminal and communicable illnesses and human diversity.

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Title

Sexual Orientation: Its Relevance to Occupational Therapy Education

Presenters

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Key Words

Occupational Science, Problem Solving

Abstract

Is an individual's sexual orientation, specifically a lesbian, gay, or bisexual orientation, relevant to the theories and practice of occupational therapy? This paper will explore the above question by, first, examining how sexual orientation may be relevant to the study of occupational science. It is suggested that for people who are lesbian, gay, or bisexual, sexual orientation may influence their choice of occupations, the context in which occupations are carried out, with whom they share occupations, the functions those occupations play in their life, the historical significance of those occupations, and the meaning they attribute to those occupations. For these reasons sexual orientation is an appropriate topic for occupational scientists to study. Second, this paper will explore how sexual orientation is relevant to the therapeutic process. Yerxa states, "Authentic occupational therapy is based upon a *commitment* to the client's realization of his own particular meaning" (1967, p.8) and "his potential in accordance with that meaning. (1967, p. 8). It is suggested that if occupational therapists are to provide authentic occupational therapy, then they must begin to enter the worlds of meaning in which their patients exist and understand how meaning is lived out in each individual's life through engagement in particular occupational patterns. For patient's who are lesbian, gay, or

bisexual, their sexual orientation may become an important symbolic theme of meaning that influences their occupational patterns, and thus needs to be addressed in the clinical reasoning process.

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GERONTOLOGY

Title

Can Balance Assessments Predict Falls in the Elderly?

Presenters

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Key Words

Balance, falls, elderly

Abstract

Performing daily living and home management activities can be impaired when older adults have poor balance.[1] The problems can be intensified if clients live where the terrain involves hills, stairs, dirt floors, snow, etc. Occupational therapists frequently assess balance to determine a client's risk for falling and need for environmental modifications and/or lifestyle adaptations. The use of objective balance measures is critically important because of proposed health care changes. The patient's performance must be documented in an objective fashion for continued reimbursement.

This workshop will begin with a brief overview of the most current motor learning and motor control literature related to balance and why balance assessment is important in the evaluation of the patient. Then, current balance measures that have predictive validity for falling, are inexpensive, and can be used in the clinic

and/or home environment will be reviewed. These include the Berg Balance Test,[2] the Clinical Test of Sensory Organization and Balance (CTSIB),[3] the Functional Reach Test,[4] the Gait Assessment Rating Scale,[5] and the Tinetti Test.[6] All have been developed within the last nine years. In addition, the equipment required to perform the test and the amount of time that it takes the Occupational therapist to administer the test will be discussed along with the reliability, validity, sensitivity, and objectivity of each measure. Using one of the falls assessment tools will augment an occupational therapy assessment and aid in treatment planning.

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Title

Model for Clinical Education: Geriatric Home Care

Presenters

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Key Words

occupational therapy education • home health • supervision

Abstract

Data from a nationwide survey of academic and clinical educators and the data analysis of three focus groups of experienced home health practitioners was the basis for identifying the critical knowledge and skills needed by occupational therapists to practice effectively with the elderly in home health. We also identified the following barriers to new graduates working in home health: (a) ageism and the lack of understanding normal aging processes; (b) bias on the part of practitioners that "new graduates should work in a hospital setting for a year or two" in order to get formal supervision and experience with the assumption that hospital based settings provide supervision focusing on the development of clinical reasoning skills; (c) a lack of formal models of supervision in community based practice; and (d) a lack of practice models for community based practice. This presentation focuses on a clinical education model that addresses these barriers.

As health care moves toward increased utilization of community care with an increased demand for OTRs to work in the community, educational programs will need to prepare OTs to competently work in the community. The clinical education model that we propose gives students experiences in a continuum of care. The fieldwork experience is structured to give students opportunities to work with older adults in the hospital and in home health. For this presentation we will focus on the following areas: the differences and similarities of each system of care, the unique knowledge and skills need in home health, strategies for clinical supervision, and supervisory issues faced by entry level graduates working in the community.

This study and the materials we have developed were funded through a grant from the Department of Health and Human Services, Allied Health Project Grants #5 D37 AH00282-03.

Title

THE MEANING OF EVERYDAY OCCUPATIONS OF FAMILY CAREGIVERS

Presenters

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Key Words

occupations, caregivers, dementia

Abstract

While many individuals provide in-home care for spouses and other family members with dementia, caregiving is not always recognized by society as a valuable and productive occupation (Daniels, 1987). The purpose of this study was to gain an understanding of the personal and social meaning inherent in caregiving occupations, and to identify the extent to which caregivers perceived their productive contributions to be recognized by others and society. Using a semi-structured format, seven individuals whose spouses were diagnosed with dementia were interviewed to elicit data related to the profile and meaning of their everyday occupations, the extent to which their occupational contributions are recognized by others, and the barriers that prevent their occupational contributions from being recognized.

The results of the study suggested that these individuals' everyday occupations are largely invisible to others. Caregiving is far more complex than the physical care tasks associated with caregiving. Our findings suggested that the anticipatory, supervisory, and protective care provided (Corcoran, 1993) is only infrequently recognized by others. When the complexity of the caregiving role is not acknowledged, the ability of caregivers to continue their caregiving occupations may be threatened.

All of the individuals expressed great feelings of loneliness and social isolation. In part, these feelings arise from diminished opportunities for social interaction with their spouse or others. Individuals reported having given up many formerly meaningful occupations, especially occupations they engaged in together with their marriage partner. Loneliness also arises from the fact that they can no longer share their experiences, thoughts, and feelings with their spouses given their deteriorating cognitive capacities. Meaningful conversations become an artifact of the past.

So why do these individuals continue to provide support to their spouse? The experience of caregiving is deeply embedded in the meaningful social relationships spouses have developed over a lifetime of being together. The meaning these individuals assign to their everyday occupations reflects a continuation of long held values--values that have evolved from both personal experiences and from socialization experiences within their families, churches, and society as a whole.

This preliminary study provided insights into why many caregivers are reluctant to ask for and accept support from others, and why support that is offered may not be accepted by caregivers. Such reluctance may reflect a combined lack of knowledge and awareness of available resources and services, together with an inability to admit their need or desire to use outside help. We must consider the implications of this situation on the development of services, on how supports and services are promoted and delivered, and on future policy initiatives. By viewing family caregiving as a productive occupation that contributes to both the social and economic well-being of our society, we can begin to identify how caregivers may be supported in this challenging role on a personal, family, community, and societal level.

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Title

Leisure in the Lives of Elderly Spousal Caregivers

Presenters

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Key Words

Leisure, Caregivers

Abstract

The rapid increase in the number of persons over the age of 70 years has made long-term health care for the elderly one of the most critical policy issues. Forced with growing pressure for long-term care services, at a time when public resources are shrinking, policy makers are increasingly looking to the family as a resource to hedge against the rising cost of health care. At the same time, social and health professionals are concerned about consequences of caregiving for the family (Carlson, 1987).

In recent years, much has been written in the health-related literature about family caregivers and their perceived well-being or sense of burden (Cantor, 1983; George & Gwyther, 1986; Hasselkus & Steton, 1991; Zarit, Reever & Bach-Peterson, 1980). The care of elderly persons in the home by spouses, is quite common, yet much remains to be learned about the caregiving experience.

The goal of this study was to deepen the understanding of the caregiver's life where well-being is threatened. This study utilized qualitative methodology, and involved multiple interviews with 10 elderly spousal caregivers living in Israel. An attempt was made to understand the personal feelings and perspectives generated by the caregiving role in the context of daily activities, social lives, and conjugal relationships.

The findings indicated that, despite apparent differences in the lives of these couples prior to the need for caregiving, their lives were now remarkably similar. The caregivers were completely engulfed by their roles. There was virtually no perceived "free" time to pursue activities that they had found in their earlier lives to be meaningful. If the caregivers engaged in any leisure activities, they were done in isolation and only to the extent that these activities helped them to be more effective caregivers. Caregiving can be understood sociologically as an experience of totality. The lives of these caregivers were transformed from compartmentalization, where components of daily life, such as work, family, and leisure can be isolated, to lives that are characterized by the predominance of a singular, totality engulfed preoccupation. In a state of totality, specific life domains are distorted and compromised (Hazan, 1981). While this existence was described by caregivers as that of being "imprisoned", the phenomenon of choosing and accepting these conditions reflected an existence of benefits as well as burdens embedded in the caregiving experience.

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Title

When Worlds Collide: OT-Caregiver Relations in Dementia Management

Presenters

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Key Words

Caregivers, Alzheimer's disease

Abstract

Caring in the home for a spouse with Alzheimer's disease (SDAT) can be a challenging, exhausting, and puzzling experience. Yet despite an implied need for support, education, and skill-building interventions, caregivers as a group have underutilized or reported limited benefits from several services, such as respite, which are specifically designed to ease the difficulties of caregiving (Lawton, Brody, and Saperstein, 1989; Zarit, 1990). Further, reports of conflicts between caregivers and service providers are common, usually involving differences in beliefs about the focus and desired outcomes of caregiving services (Corcoran, 1993; Hasselkus, 1988). This implies a knowledge gap about the range of caregiving experiences and caregivers' perceived needs which influence service use and outcomes.

The purpose of the qualitative study reported in this presentation is to describe one aspect of the caregiving experience - how spousal caregivers define, make decisions about, and manage problems behaviors related to dementia. Subjects are 26 spousal caregivers who provide self-care assistance to a spouse with moderate impairment from SDAT. This study has implications for occupational therapy interventions designed to build caregivers skills for controlling the problems associated with dementia.

In this presentation, two central findings from the study will be reported. First, grounded theory analysis of subject interviews revealed several principles, or beliefs, which are used by spousal caregivers to assess and manage care problems. Once isolated, further analysis suggested that caregivers organize these principles into three gender-related *caregiving styles*, labeled by the investigator as *Enforcing, Preserving*, and *Enabling*. Caregivers in the study preferred one of these three overlapping, but distinctive caregiving styles. Second, comparison of each caregiving style with corresponding occupational therapy treatment documentation indicated interesting trends in the source and resolution of OT-caregiver conflicts. Occupational therapists in the study established an effective therapeutic relationship with caregivers who preferred an *Enforcing* or *Enabling* approach to their role, but experienced multiple conflicts with *Preserving* caregivers. Implications for establishing effective therapeutic relationships with caregivers are offered, including methods for identifying and making suggestions consistent with the caregiver's preferred style.

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Title

Structured Observational Test of Function (SOTOF):
Clinical and Research Applications

Presenters

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Key Words

assessment
occupational performance
perceptual - cognitive component

Abstract

The Structured Observational Test of Function (SOTOF) (Laver, 1994a and 1994b: Laver and Powell, 1994) is a clinical assessment which provides accurate, cost effective evaluation of the impact of neurological deficits on older adults' ability to engage in daily tasks. SOTOF enables clinicians to undertake synchronous evaluation of the individual's performance of Activities of Daily Living (ADL) and the underlying neuropsychological function. SOTOF is founded on an interdisciplinary conceptual framework drawn from neuropsychological, occupational therapy and general systems theory. This conceptual framework has been applied to the task of eating, washing, drinking and dressing using activity analysis to extrapolate the skills, performance, and a neuropsychological check-list. Studies have been undertaken to evaluate the psychometric properties and clinical utility of SOTOF. Results indicate the SOTOF is a valid, reliable and clinically useful tool that provides information regarding the relationship between an individual's neurological deficits and ADL performance. The SOTOF identifies information related to four different levels of functioning: disability, functional limitation, impairment and pathophysiology (NCMRR, 1992):

- disability: the patients' residual occupational performance in the domain of ADL (by examining ability to perform simple ADL tasks such as feeding and dressing);
- functional limitation: the patients' residual and deficit skills and abilities within ADL performance (for example reaching, scanning, grasping and sequencing);
- impairment: the performance components that have been affected (perceptual, cognitive, motor, and sensory);
- pathophysiology: the specific neuropsychological deficits (for example apraxia, agnosia, aphasia, spasticity, and memory deficits).

SOTOF is a descriptive test that serves as a screening tool to identify clients whose functional performance in ADL is sufficiently affected to require intervention. SOTOF is suitable for evaluative purposes as it has been shown to possess test-retest reliability. The SOTOF was developed for the evaluation of older adults with suspected neurological dysfunction arising from stroke; and is designed to be used from the onset of stroke to provide a global picture of occupational performance, skills, performance components and underlying neuropsychological deficits. Later studies also included samples of patients with dementia, indicating that SOTOF is a useful evaluation of patients in the moderate to severe stages of dementia.

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National Council for Medical Rehabilitation Research (NCMRR). (1992). *Report and Plan for Medical Rehabilitation Research to Congress*. National Center for Medical Rehabilitation Research, Bethesda, Maryland: National Institute for Child Health and Human Development, National Institutes of Health.

The SOTOF is available from:

NFER-Nelson
Darville House, 2, Oxford Road East
Windsor, Berskhire, SL41DF
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Tel: 011 44 753 858961 Cost £59.95 (+VAT)

Title

Implementing OBRA: A resident-centered model of long-term care.

Presenters

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Key Words

Long-term care
Ethics

Abstract

Occupational therapists working in long-term care are often frustrated by a system of care that reinforces dependence (Barton, Baltes, & Orzech, 1980) and leads to excess disabilities (Dawson, Kline, Wiancko, & Wells, 1986). The medical model does not lend itself well to providing housing and assistance to persons with chronic disabilities (Estes & Binney, 1989). As the population requiring care becomes more diverse in lifestyle and ethnicity, the need for individualized care will become even more apparent. The literature offers conceptual guidance, but little in the way of practical models. Kari and Michels (1991) describe the Lazarus Project which works to transform the way decisions are made in one facility, but few other OT perspectives have been published. There is a need for occupational therapists to become aware of alternative models so that they can serve as change agents in the facilities where they work.

This paper is based on a study of innovative British long-term care facilities which have implemented interventions leading to a more normalized environment and personalized, resident-centered care (Barker, 1987; Kayser-Jones, 1981). These transformed facilities offer the US a vision of what could be achieved if the intent of the OBRA residents' rights regulations (Department of Health and Human Services, 1989) were followed. OTs need first to examine our own assumptions and practices, and then set an example for other disciplines in order to help create an environment with improved quality of life for residents and staff alike. This information is valuable not only to therapists currently employed in long-term care, but also to anyone who has or will have family members and friends needing nursing home services.

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Title

EMPOWERING THE GERIATRIC CLIENT

Presenters

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Key Words

empowerment; motivation; geriatrics

Abstract

Empowerment - the buzz word for the nineties. But just how is it manifested when treating the geriatric client? In long term care, many of the client's choices are taken away from them. They often feel helpless and forced into accepting whatever happens to them. When treating a geriatric client it is important for the occupational therapist to give as much autonomy to the client as possible. At times the older client in long term care is unable to understand how occupational therapy can be of benefit to them. It is the role of the therapist to help them to determine the relevance of treatment and to empower them to participate.

Several basic techniques have been employed in our facility to help the client feel empowered to participate in treatment. Some of the techniques used are as follows:

* Active Listening- let the client know that you are

interested in hearing and understanding what they are telling you

* Contract with the client- written or verbal agreement between client and therapist indicating number and type of treatments

* Choices- give choices whenever possible,even when they may seem trivial

* Problem solving- work out solutions with the client, encourage them to brainstorm

* Consistency- provide consistent relationships and schedules

* Education- provide information about their illness, nursing home routine, client rights, etc...

The elderly population will continue to increase dramatically into the next century. As that population grows, so will the number of therapist needed to serve them. Occupational therapist are faced with the challenge of not only providing state of the art treatment for the client, but also with providing it in a way that is purposeful and meaningful.

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Title THERAPISTS' ROLE: STRESS REDUCTION FOR PEOPLE WITH DEMENTIA

Presenters

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Key Words

DEMENTIA, STRESS, STRENGTHS

Abstract

It is well documented that the losses experienced by the elderly will lead to increased stress and result in functional decline. This same reaction to stress is also seen in the person with dementia and is intensified when this person is in an institutional setting. As Occupational Therapists working with this population we can intervene to reduce the resulting stress.

If the therapist assists in program development that will utilize the individuals strengths and adapts the environment to emphasize function, this stressful reaction to an ever changing world can be reduced. ADL's can be set up for success. For the ill population with dementia, particularly in an institutional setting, maintaining ADL skills is exceptionally difficult. Regardless of lifelong personal routine, they must fit into the daily institutional routine and this is particularly difficult for the approximately 80% of the long term care community that is cognitively impaired.

The Occupational Therapist can objectively evaluate the institutional environment that is frequently missing familiar areas which prompt functional behaviors. For example, an institutional dining area does not look like a place to eat, nor does the food or serving method look familiar.

Unfortunately the frequent response of facility staff to difficulties with self-care tends to be to do it for the person rather than design environments, programs and individualized interventions to encourage independence in ADL's. Consequently these residents become deprived of participation in essential ADL's which leads to devastation of their self-esteem and results in increased stress.

ADL routine can be individualized according to personal habits, and functional behavior can be encouraged through cueing procedural memory. An Occupational Therapist should develop an awareness in the care staff of how different people approach ADL's. Culture; family patterns, lifestyle, willingness to take risks, as well as other factors influence our uniqueness. Therapists can derive benefit from the diversity of the multi-cultural facility staff. How we develop an appreciation and respect for this uniqueness is one of the objectives of this presentation.

The experienced practitioner can develop systems and techniques and work with facility staff to reduce stress for their residents. This includes care needs focusing on strengths of the individual, reducing trauma when a individual needs to be transferred to acute care temporarily and providing communication systems that promote interaction. The experienced practitioner needs to develop expertise in dealing with service extenders. In this changing health care environment reduction of the cost of care delivery will become increasingly more important. We have the knowledge as therapists to modify environments, techniques and service delivery to enhance function. We must apply our knowledge to increase function in our institutionalized people with dementia and therby reduce their stress as they deal with a constantly chaning world.

Title Interdisciplinary Screening

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Key Words Interdisciplinary Screening
Meeting OBRA guidelines
Part - B Utilization

Abstract An unprecedented set of federal nursing facility reform requirements were recently adopted in the Omnibus Budget Reconciliation Act (OBRA) of 1987 and additional clarifying legislation in OBRA 1990. The most notable changes require increased resident assessment, care planning and documentation, elimination of restraints, a higher commitment to quality of life, and aggressive efforts to maintain each resident at their highest practical level of functioning.

All these items impact the delivery of occupational therapy services increasing the time demands to complete the Minimum Data Set Assessment (MDSA), participate in the facility's restraint and/or positioning screening program and developing programs for nursing to maintain their residents at the highest practical level of functioning while not necessarily providing the financial resources to provide these services.

There is a need for periodic (quarterly) screening of residents to meet OBRA guidelines, with an instrument that is sensitive to change while not being unwieldy or lengthy.

Utilizing the entire rehabilitation team (occupational therapy, physical therapy, and speech-language pathology) to perform the Interdisciplinary Screening Program allows a reduction in the total number of patients to screen, greater time efficiency and a greater understanding of the roles the other disciplines play in the rehabilitation process.

The Rehabilitation Screening Worksheet was created to provide therapists with an interdisciplinary screening tool to quickly get a gross assessment of a resident's level of function in skilled nursing facilities. The screening worksheet was designed and written for all levels of therapists, including occupational therapists, physical therapists, and speech language pathologists, to screen long-term care residents. This process can identify problem areas or concerns, which can trigger a more discipline-specific screening or evaluation.

The Rehabilitation Screening Worksheet can assist a program to:

1. Meet OBRA guidelines by screening residents quarterly.
2. Assist nursing in accurately computing initial and quarterly MDSA (minimum data set assessments).
3. Provide a form to document initial resident's function, highest and or baseline level of finction, and quarterly note changes.
4. Increase appropriate caseload through early detection and periodic follow-up.
5. Foster awareness of the other disciplines and their role in the rehabilitation process.
6. Increase time efficiency by distributing residents to be screened to all treating therapists.

Title

Differences in Male and Female Performance on the Assessment of Motor and Process Skills

Presenters

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Key Words

Gender Differences, Instrumental Activities of Daily Living (IADL) Assessment

Abstract

There is evidence that performance of instrumental activities of daily living (IADL) tasks, such as meal preparation and housework, is influenced by societal gender role expectations. Men often are at a disadvantage when they are assessed using global assessments of IADL ability because of their limited experience performing certain IADL tasks. In contrast to most IADL assessments, the Assessment of Motor and Process Skills (AMPS) is unique in that both men and women are scored on motor and process skill constituents in the context of performing familiar, practiced, and self-chosen IADL tasks. These motor and process skill constituents are hypothesized to be gender-free when a person performs a task he or she has had experience performing.

Many-faceted Rasch analysis was used to examine the AMPS motor and process scales for differential item response in a sample of more than 3500 men and women from the standardization sample for the pilot version of the AMPS computer scoring software. We also compared mean motor and process ability measures of age-matched subgroups of men and women.

Of the 35 AMPS items only one item, Lifts, was significantly different between men and women, but the difference was not enough to cause a significant disruption in the final estimation of client ability. Men and women did not differ significantly in mean motor ability, but women on the whole were more able than men in mean process ability.

The results suggest that the AMPS motor and process skill items are stable between men and women, and the AMPS is free from gender bias. The findings also suggest that men and women do not differ in motor ability in the context of performing familiar and practiced IADL tasks, but that women are be more able than men in IADL process ability.

Title

Assistive Technology in the Nursing Home: Positioning Can Make a Difference

Presenters

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Key Words

Seating and Positioning-Elderly-Long-Term Care

Abstract

Seating and positioning can be an integral component of occupational therapy treatment in the long-term care setting. The high incidence of seating and positioning deficits in the older adult population will be examined. Specific postural deficits in this population will be addressed. Medical and functional complications of prolonged abnormality in the seated posture will be discussed.

Common treatment equipment modalities required for this population will be noted. Funding issues/alternatives will be briefly addressed.

The need for cost effective, quality oriented programming will be highlighted.

Title ASSISTIVE DEVICE NEEDS AND FUNCTIONAL STATUS OF OLDER ADULTS

Presenters

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Key Words

Adaptive equipment, Home rehabilitation, Geriatrics

Abstract

Statement of the Problem: Hospitalized older adults frequently receive adaptive equipment during the rehabilitation phase of their recovery as a strategy to increase their functional performance (Gitlin, Levine, Geiger, 1993; Geiger, 1990). Therapists use the patient's medical diagnosis, functional needs, and an intuitive impression of the patient's motivation and culture to make equipment choices (Gitlin & Burgh, in press).

Method of Study: This three-year, federally-funded study describes the kinds of devices routinely given during rehabilitation to a group of older adults with the primary diagnosis of cerebrovascular accident, hip fracture, or lower limb amputation. Two hundred fifty subjects, recruited over a twenty-month period, were examined prior to their discharge from two rehabilitation settings. Relationships between the subject's level of function (FIM score), background characteristics, number and type of devices prescribed by physical or occupational therapists were compared. The study analyzed categorical variables using cross tab frequency distributions with chi-square statistics. The characteristics of older adults within each of the three diagnostic groups are compared, as are the continuous variables, using analysis of variance (ANOVA).

Results: Of the 250 subjects, 103 had a primary diagnosis of a CVA, 116 had an orthopedic deficit, and 31 had a lower limb amputation. The groups were largely female, Caucasian, retired, unmarried, and of varied religious backgrounds at the time of data collection. Years of education were similar for all groups (X-11.10 ± 3.48), and subjects had an average of four previous or secondary diagnoses (± 1.90, range 0-12). At discharge from the rehabilitation program, subjects functioned at a moderate level of independence (total FIM X = 96.82, ±11.63, Range 16-112) and reported an average of 1.05 devices in their homes before this hospitalization (± 1.40, range 0-8). During rehabilitation, a total of 1,885 devices, or an average of eight devices per subject (± 3.61, range 1-18) were issued. Ninety-four percent of the subjects received mobility devices. Of interest to occupational therapists was that 84% of the subjects received bathing aids, and 76% of the sample received one to five dressing aids. More dressing aids were issued per person when compared to bathing aids.

Chi-square statistics indicated significant differences as to the proportions of subjects in each group who received assistive devices. Subjects in the CVA group were issued more seating and feeding aids than in the orthopedic group; the orthopedic group was issued more aids for dressing than those in the other two groups; and, subjects with a lower limb amputation were issued more mobility and grooming aids than subjects in the other two groups.

Conclusions: In spite of differences in functional level of independence, most subjects were issued an average of eight devices, and the patient's diagnosis influenced the selections. Further research is necessary to determine what factors serve as indicators of the best allocation of assistive devices in these times of shrinking resources.

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Title

Structuring Fieldwork to Enhance Work With Older Adults

Presenters

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Key Words

Geriatrics, Education, Fieldwork

Abstract

The convergence of two dramatic demographic trends, the fast paced growth of the older population and increased incidence of disability due to prolonged life span, creates the need for enhancing geriatric training to prepare occupational therapists to work with today's older adults. To address this need, a model project has been developed that embeds content on aging throughout courses in an occupational therapy curriculum and enriches Level I fieldwork training. To be successful, this approach requires careful collaboration and cooperation between academic and fieldwork educators in order to structure fieldwork experiences that build upon and enhance didactic geriatric course work.

Unique aspects of the project include: 1) the integration of content on aging throughout the curriculum rather than appending it as a single course; and 2) the expansion and intensification of fieldwork training to include a variety of settings within the community. The result of the one-week intensive fieldwork experience for the student provides a more realistic and in-depth experience of working with older adults, enriches learning, and provides ample opportunity to experience "best practice" in the geriatric practice arena.

A capstone course on geriatric practice is taught in the final quarter of the curriculum and includes a one-week, 40-hour Level I fieldwork placement. This fieldwork occurs in the fifth week of the ten-week quarter and has been designed with fieldwork educators to complement and enhance classroom learning. The process used to design the fieldwork experience includes meetings with the clinical educators to develop objectives and learning experiences, inservice presentations to enhance clinical educator skills, and a follow-up meeting to "de-brief" on the fieldwork experience. The final meeting includes a review of student feedback, clinical educator feedback, and student performance reports. Throughout the process, the emphasis is on collaborative planning and coordination of fieldwork experiences to enhance classroom learning.

In summary, an overview of a model for enhancing occupational therapy education in geriatrics, specific didactic and fieldwork components, and the outcome measurement process is presented. It is hoped that this information will assist clinical educators who wish to strengthen their geriatric training so as to meet the increased demands for occupational therapists to work with older adults.

Title

CULTURAL DIFFERENCES IN THE WELLNESS OF ELDERLY PERSONS

Presenters

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Key Words

Cultural Diversity, Wellness, Health Promotion, Minority Elderly

Abstract

This Roundtable discussion will address issues related to cultural diversity in minority elderly clients that have an impact on lifestyle patterns which OTs can consider in individualizing programs. Issues related to wellness as a lifestyle for well-being will be considered.

Roundtable: CULTURAL DIFFERENCES IN THE WELLNESS OF ELDERLY PERSONS

The purpose of this Roundtable is to facilitate a discussion about the wellness of elderly individuals with different cultural orientations and how those who work with the elderly population can help them experience wellbeing. If we recognize that ethnic, cultural, and individual differences exist among elderly individuals, we will become more sensitive to each person's uniqueness. This will lead to a reduction in stereotypic beliefs that interfere with effective provision of service McCormack (1987) pointed out the importance of realizing that health beliefs and practices of elderly minority Americans differ greatly from Caucasians. Spector (1985) stated that service providers who understand socio-cultural diversity will be more sensitive to their patient's needs when engaging in treatment planning. Occupational therapists can have a significant impact on the lives of their clients when they consider cultural differences that influence the choice of occupations or adaptation to the stresses of daily living. Believers in wellness as lifestyle for wellbeing (Ryan and Travis, 1988) or as a context for living (Johnson, 1986) accept the premiss that how one lives enhances or diminishes chances for maintaining functional independence and achieving one's potential.

The presentation is based on the results of a qualitative research study completed by the presenter which identified themes as to how four well-elderly persons from each Black, White, Hispanic, Vietnamese and German ethnic group manage their lives and adapt to life transitions. The themes that emerged across all of the ethnic groups that relate to a wellness lifestyle were social interaction, spirituality, exercise and nutrition, balance of work-leisure, stress management, environmental factors and occupations. There were, however, variations in how each informant operationalized these wellness factors. If therapists realize that these individual differences exist, they can be more effective in helping their clients adapt to crises or make significant changes in how they live so that they can attain a lifestyle for wellbeing.

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MENTAL HEALTH

Title The Art of Setting Limits

Presenters

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Key Words

Assertiveness
Communication
Professional - Patient Relations
Clinical Competence
Fieldwork Education

Abstract

Setting limits is an important part of practice that most occupational therapists recognize, yet it is a vague concept. Though related to other popular topics,(Robinson,1986;Cottrell,1993;Davis,1989;Purtilo,1991) it is rarely addressed in occupational therapy literature and practice. In other health areas it is associated with developmental disabilities, child-family and child-parent interactions.(Benson,1986;Griffiths,1990;Silverstein et al, 1987). It is also associated with psychoanalytic, psychodynamic and behavior therapy (Hartman,1989;Lapkin,1985;Lehrman,1991;Tirnauer,1988).

"Setting limits" is a concept and behavior that students identify as difficult to grasp. It is assumed that they will learn how to communicate with clients or how to handle difficult behaviors during their practicum and fieldwork experiences.

In identifying problems in clinical education, clinical educators have acknowledged that a cost-containment effort has resulted in limiting staff involvement in fieldwork education. They have suggested models in the community in which students would not be supervised by registered occupational therapists,"so would need to use their own skills of discernment and knowledge" (Dawson,1993,p.6). They have suggested a"new view of

psychosocial occupational therapy in which students would develop an ability to apply principles of psychosocial practice to a variety of areas in occupational therapy"(Dawson,1993,p.6). They have posed the question, is there a model that responds to current trends, yet also provides excellent clinical training.(Crist,1993,p.6)

These new trends and responses to health care and education needs pose the question,"how will students learn clinical communication, and who will model how to interact in the clinic?

Not learning the skills for limit setting has consequences for both therapist and client. Clinicians may feel taken advantage of, manipulated, fearful. They may blame clients or avoid them. They may feel inadequate, incompetent and "burn out".

Clients may feel frustrated, uncared for or not helped. They may feel fearful, out of control. They may blame therapists or avoid them. They may feel inadequate, helpless and that they are treatment failures.

Learning how to set limits is an important psychosocial aspect of most interactions in most settings. Knowing limit setting leads to competency for therapists in clinical practice and for clients in treatment. It is a skill that may be overlooked in the classroom, and may not be included in fieldwork or in supervision.

This workshop presents a model for matching limit setting techniques with another's behavior in specific situations. Participants will learn and practice strategies and techniques. It will provide modeling for those who lacked this aspect in their fieldwork. It will provide clinical educators with a quick and efficient model to teach limit setting and communication.

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Title

Validity and Reliability of the Milwaukee Evaluation of Daily Living Skills (MEDLS)

Presenters

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Key Words

Assessment Process, Activities of Daily Living, Occupational Therapy in Psychiatry

Abstract

The Milwaukee Evaluation of Daily Living Skills (MEDLS) was developed in order to provide a measure of the behavioral performance of basic Activities of Daily Living (ADLs) and Instrumental Activities (IADLs) for persons with long-term mental illness (Leonardelli, 1988). Its development used traditional measurement theory approaches to establish content validity and interrater reliability. In its original form, the MEDLS consisted of 20 subtests (skill areas) of ADL and IADL which were selected to be used based on a client's anticipated deficits and needs. When published the MEDLS had standard administration procedures, specific criteria for skills, content validity, interrater reliability, and was appropriate for many types of mental health settings.

The reliability, construct validity, and difficulty of test items on the MEDLS were recently reexamined using modern test construction approaches, specifically the Rasch model of analysis. A revised version of the MEDLS, with items divided along two hypothesized scales of performance (P-Scale) and knowledge/judgement (K/J-Scale), was administered to 100 persons

with long-term mental illness. The data analysis confirmed the validity of the hypothesized scales with most subtests having items on both scales. other results show that there is logical order of item difficulty on both scales (although basic ADL skills are not always easier than what appear to be more complex IADL skills); the P-Scale can be scored reliably by different raters whereas revisions need to be made to the K/J-Scale for comparable reliability; the scales are most suitable for more impaired persons with long-term mental illness; and scores on the MEDLS scales do not differentiate among subgroups of the target population.

Rasch analysis of the revised MEDLS provided comprehensive and detailed reliability and validity data which will contribute to planned revisions and further analysis. Possible revisions include dividing the K/J-Scale into two scales (knowledge and judgement), clarifying scoring procedures, eliminating redundant items, expanding rater training for the K/J-Scale, and developing more difficult subtests and items. Future analyses include administering the MEDLS to larger and lower functioning sample groups and correlating scores on the MEDLS with support services available.

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Title

VALIDATING MOSEY'S DEVELOPMENTAL GROUP CONCEPTS EMPLOYING STUDENT INVESTIGATORS

Presenters

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Key Words

Group structure
Concept formation
Research, students, occupational therapy

Abstract

Two occupational therapy faculty members working with professional level graduate students at New York University have begun to study the validity of Anne Mosey's (1970 and 1986) developmental group concepts.

Mosey's group concepts, entitled parallel, project, egocentric-cooperative, cooperative, and mature, represent constructs for assessing small group performance and for structuring activity treatment groups, primarily in mental health settings. Mosey postulated that these group constructs simulated group behavior in normal persons from the age of 18 months to that of 18 years.

Occupational therapy students in a professional Master's program have assisted in reviewing literature and gathering data in an attempt to determine the validity (Benson and Clark, 1982) and practical usefulness of Mosey's group concepts. The following steps in this effort to measure validity have already been undertaken:

1) Two students reviewed developmental and educational literature, tracing the sources of Mosey's five major terms and descriptions of their application and investigation.
2) Student investigators, using initial observation instruments, conducted a series of structured observations of persons of varied ages engaged in diverse natural groups and some groups of occupational therapy clients in treatment settings.
3) Data from these initial observations were evaluated and analyzed.
4) Faculty and clinical experts developed four rank ordered scales based on these data.
5) Scales have been and are currently being revised as warranted by new data.
6) Clearance was obtained from the university human subjects research review panel to continue data collection in a variety of institutional and natural settings.
7) Additional data have been collected through observations of groups of varied types, backgrounds, and age levels, using the most recently developed observation instruments.

In the future, experienced occupational therapy clinicians and small group leaders will review the scales and the data collected. Further revision of the scales will be based on these findings, and continuing field investigation as part of involvement in ongoing research.

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Title

Religious Affiliation as an Occupational Role

Presenters

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Key Words

occupational behavior
health promotion
individuality

Abstract

Occupational therapists are health professionals who value an holistic approach in the management and prevention of disabilities. Acknowledgment of cultural and racial diversity in treatment planning has become mainstream, however awareness of religious diversity and its impact on occupational behavior is not as recognized within the profession. In an effort to establish if occupational therapists and their patients consider this an important aspect of treatment, several interviews were conducted. General themes which emerged included 1. spirituality is considered a value and religious affiliation is considered more of a habit or practice of attending church. More people preferred to

identify with the former. 2. Considering religious affiliation or spiritual values is important in treatment but no often done. 3. more study is needed in this area. The results indicated a strong need for continued formal study in this area as well as education to occupational therapists on how to address this area of human diversity within an occupational behavior frame of reference.

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Title Spirituality, Health, and Occupational Therapy

Presenters

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Key Words

Holistic health, coping skills

Abstract

Humans have demonstrated the ability to overcome tremendous adversity. They find meaning and hope in the most deplorable of circumstances. Frankl (1962), wrote of the ability of concentration camp victims to grow spiritually in spite of physical and mental torture. But what is spirituality? Colliton (1981) defined spirituality as "the life principle that pervades a person's entire being, including volitional, emotional, moral ethical, intellectual, physical dimensions, and the capacity for transcendent values" (p. 248). Occupational therapists, as holistic practitioner, have traditionally stressed the interconnectedness of body, mind, and spirit (White, 1986).

A rapidly increasing number of health care professionals have begun to investigate spirituality and how it affects one's health? One indicator of spirituality used by many researchers is spiritual well-being, "...an affirmation of life and of the lives of others, together with concerns for one's community, society, and the whole of creation" (Moberg, 1979, p.2). Spiritual well-being has been operationalized by Paloutzian and Ellison (Ellison, 1983) who

developed the spiritual well-being scale. This scale measured both religious and existential well-being. Using the scale, a variety of researchers have found spiritual well-being to correlate in a positive manner with hardiness (Carson & Green, 1992); acceptance of mortality and feelings of well-being among the terminally ill (Reed, 1987); hope (Carson , Soeken, and Grimm, 1988); acceptance of mortality and feelings of loneliness (Miller, 1985); decreased anxiety (Kaczorowski, 1988); and purpose of life (Burns and Smith, 1991). Spiritual well-being has been found to be negatively correlated with depression (Fehring, Brennen, and Keller, 1989).

Individuals who are terminally ill, those who are depressed, have limited function, or have chronic pain may experience feelings of hopelessness, isolation, loneliness, alienation, and decreased self worth. Caring, concerned occupational therapists can learn to facilitate spiritual growth through the use of art, music, photography, literature, dance, and story telling.

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Title

The Concept of Time: Its Cultural and Functional Implications

Presenters

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Key Words

Culture (Anthropology), Time, Trends, Occupational Therapy

Abstract

According to Barris, Kielhofner & Watts (1988) "the theme of time or temporal adaptation is one of the earliest and most central concepts of occupational therapy", articulated by early leaders in the field such as Adolf Meyer (1922). In practice, occupational therapists use many assessments that explore time sense and orientation. Among them are variations of activity configurations, mental status exams, interest checklists, and functional living skills evaluations.

Yet time itself is a theoretical construct that is laden with cultural value judgments (Hall, 1976). In order for occupational therapists to provide culturally competent treatment to a diverse population it is essential that an exploration of the professions' beliefs about time be explored. The anthropologist, E.T. Hall identified societies as either being based on Monochronic time (M-Time), such as Northern & Western European, European American and "Westernized" Cultures, or being based on Polychronic time (P-Time), such as Middle Eastern, Latin American and Native American cultures.

Occupational therapy originally developed in a M-time society but must adapt to include, or at least recognize, the values of other societies. M-Time societies view time as linear and therefore its' members typically prefer to do one thing at a time. People in M-time societies also tend to view time as a commodity; a thing that can be saved / lost, spent / wasted, squandered / managed. Peloquin (1993) describes the clinical concerns of viewing time as a commodity, however, P-time cultures do not share the same time values. P-Time tends to be cyclical and unscheduled, typically viewing time as a natural rhythm where several things can happen at once and is not controlled by human beings.

Hall applied the concepts of M-Time and P-Time to specific cultural and societal groups. But the concepts are also useful in understanding the difference in temporality of various age groups and different genders. Furthermore, certain disorders can markedly change a person's sense of time. Among these conditions are acute and chronic pain, brain injury, dementia, and Schizophrenia.

There are many implications for treatment when the therapist has a different time sense than the person receiving services. The trends towards managed care and increased productivity in the work place have placed a high value on a minute increment therapy model, in which quantity of therapy minutes is equated with quality of intervention. How are these trends reconciled with the trends towards incorporating multi-cultural and individual consumer perspectives?

In summary, occupational therapists must sensitize themselves to the relationship between time and ethnicity, gender, age, and diagnosis. In order to develop such sensitivity, one must explore personal and cultural biases about time as well as critique the profession's values regarding time.

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Title

Mental Health SIS Program: Guidelines for Mental Health Service Delivery

Presenters

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Key Words

Mental Health

Abstract

Occupational therapy practice in mental health has been significantly influenced by recent trends in mental health and the changing health care environment. Gibson, in 1989, identified five major trends that have impacted mental health occupational therapy practice:

- Decreased length of inpatient stays and subsequent increased severity of illness.
- Expanded options in treatment settings.
- Neuroscientific advances.
- Increased consumerism and public awareness.
- Personnel shortages.

The declining numbers of occupational therapists choosing mental health as a practice arena have been of great concern to the profession. Many factors have contributed to

the declining number of practitioners including the stigma of mental illness, role confusion, lack of financial incentives, and the abstract nature of psychiatry. The current emphasis in health care is moving away from inpatient hospital based care and towards a broad continuum of services including partial hospital, home health services, and psychiatric rehabilitation. This changing emphasis provides occupational therapy with both opportunity and challenge.

In 1991, AOTA's Representative Assembly charged the Executive Board to make mental health a priority in the Association's Long Range Plan. The Commission on Practice supported this charge with the appointment of the Mental Health Service Delivery Guidelines Task Force.

The charge to the task force from COP was to develop guidelines for mental health practice that would highlight mental health as a specialty, provide mental health practitioners with problem-solving approaches to critical issues, and help them prepare for revised and expanded roles in the changing healthcare delivery system.

The guidelines were developed with the following principles in mind: to honor the roots and traditions of early Occupational Therapy, to acknowledge the difficulty of practicing in today's health care arena, to provide practitioners with easily accessible information and strategies to meet current challenges, to highlight examples of good practice and finally to make the guidelines relevant to current practitioners.

The material developed for the guidelines has been divided into three sections. The first section, "Mental Health Practice Issues: Moving to the Future with a Look to the Past," provides a review of mental health practice beginning with early practice in the 19th century and ending with the current trends and future challenges that will face us as we move our practice into the 21st century. Section two, "Guidelines," provides information, strategies, and tools, which address many of the common practice dilemmas faced by mental health practitioners today. This section describes the planning process for service delivery, setting priorities for treatment, program development, marketing, and innovative practitioner roles. Additionally, this section covers such areas as standards of practice, accreditation and reimbursement guidelines, and ethical and legal considerations of practice. The third section, "Vignettes," contains case examples and vignettes of current practice which illustrate the principles described in the "Guidelines" portion of the manual.

Mental Health is a diverse area of practice with enormous potential for significant contributions to the health care service delivery system. The Task Force hopes that these guidelines will inspire new Occupational Therapists as well as encourage those experienced in Mental Health to provide meaningful, carefully planned, and cost-effective services.

Gibson, D. (1989). Requisites for excellence: Structure and process in delivering psychiatric care. *Occupational Therapy in Mental Health, 9,* 27-52.

Title SOCIAL INTERACTION AND COGNITIVE DISABILITY RELATED TO PSYCHIATRIC DISORDERS

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Key Words COGNITIVE DISABILITY, MENTAL HEALTH, SOCIAL SKILLS

Abstract Observing that the degree of cognitive disability was inconsistent with other aspects of psychiatric disorders, this research compares social interaction skills as measured on the Social Interaction Test (Trower, et al. 1978) with cognitive disability as measured on the ACL-90, developed by Claudia Allen (Allen, 1990).

A low correlation between the two assessment tools would suggest that the variables being measured are unrelated or reflect inconsistently appearing symptoms. If unrelated, effective treatment would require a more comprehensive assessment of needs. Any skill areas in addition to the two measured by these tools would need to be explored. In effective clinical practice, a thorough review of the planned discharge environment would be need to determine the appropriate skills to be assessed, and further, prioritizing options for treatment.

Conversely, a high correlation would facilitate the assessment and treatment planning process, as reliable assumptions could be made from an evaluation of only one of the skill areas. Further research, then, could address the concept that treatment in one of the skill areas could possibly reduce symptomatology in the other.

A total of fifty nine (59) inpatients participated in this study. Each was administered an ACL and rated on the SIT by an independent observer. Two groups of examiners were used. One group was trained in administering and rating the ACL. The other group was trained in rating the SIT. In conducting the study, an ACL examiner would conduct the facility's standard activities interview and then administer the ACL. The SIT examiner would observe the interview, depart before the administration of the ACL, and then assign a rating. Each examiner was knowledgeable of his or her assessment tool only. Rater reliability was measured by randomly assigning two observers to either of the tasks. These independent ratings demonstrated a high inter-rater reliability.

Collected data included: diagnosis, length of current hospital stay, age, gender, ethnic background, number of prior hospitalizations, age of onset, presence of hallucinations or delusions, substance abuse prior to current admission, DSM-IIIR Axis V rating, living arrangement at the time of admission, education level, and employment status for the three months prior to hospitalization.

A significant relationship was demonstrated between the ACL-90 and the overall SIT, as well as the SIT subtests of Conversation and Non-Verbal. A correlation between ACL-90 and SIT subtest of Voice Quality could not be demonstrated.

The presentation reviewed the observations that lead to this study. The two assessment tools were briefly described. Related prior research was reviewed. Visual aids included graphic presentations of the major findings of the data. Implication of the results of this project were addressed.

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Title

Establishing Standardization for the Toglia Categorization Assessment Test

Presenters

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Key Words

Assessment; Cognition; Brain-injured; Schizophrenia.

Abstract

The purpose of this presentation is to examine the Toglia Categorization Assessment -TCA (Toglia, 1994) as a new evaluation instrument for the assessment of cognitive categorization skills. The aim of this study was to establish inter-rater reliability and concurrent Validity for the TCA, based on a comparison between the TCA and the Riska Object Classification (ROC) test.

The ability to Categorize is a fundamental cognitive process, integrally involved in every intellectual endeavor (Markman, 1989), and essential to the performance of daily tasks.

Occupational therapists have observed cognitive categorization performance deficits in both brain-injured and certain psychiatric populations, with many patients manifesting a diminished capacity for daily task function. (Baum and Hall, 1981).

Cognitive or neuropsychological deficits in schizophrenia are current focal areas of research and treatment, and include problems of attention, concentration and memory, as well as impaired abstraction and concept formation abilities (Stuve, Erickson & Spaulding, 1991). Theory and methods of intervention developed for treating cognitive difficulties of brain-injured persons have been applied to the chronic mentally-ill with similar problems.

The TCA evaluates cognitive categorization ability of brain-injured persons by employing meaningful objects, and is based on empirical evidence of enhanced response patterns and also increased clinical progress with patients (Rahmani, 1982).

The ROC (Riska, 1985) is well-established instrument which evaluates the cognitive categorization ability of normal subjects by use of abstract objects. It has been utilized to evaluate categorization ability in both brain-injured and mentally-ill adults and adolescents (Katz, Josman & Steinmetz, 1988; Katz, Itzkovich, Averbuch & Elazar, 1989).

The study sample consisted of 35 brain-injured and 35 schizophrenic persons (n=70). Results show similar categorization functioning for brain-injured and schizophrenic persons. Moderate correlations between both sub-tests of the ROC and TCA were obtained, suggesting that these respective tests possibly address different cognitive abilities. The TCA appears to be a more sensitive tool, providing a richer and more elaborate cognitive profile. Implications for theory and measurement, and also clinical practice and research are discussed.

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Title Locus of Control in African-Americans and European-Americans

Presenters

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Key Words

Model of Human Occupation, cross-cultural occupational therapy

Abstract

A quasi-experimental study examined the cross-cultural validity of the Model of Human Occupation's (Kielhofner, 1985) assumption that an external locus of control (LOC) represents dysfunction. Differences between nondysfunctional African and European Americans' LOC beliefs were compared using a unidimensional and a multidimensional tool, the Rotter Internal-External Scale (Rotter, 1966) and the Reid-Ware Three-Factor Internal-External Scale (Reid & Ware, 1973, 1974). Non-probability purposive sampling was used to select 43 subjects, 19 African Americans and 24 European Americans, from two Methodist congregations. An ANCOVA with age as a covariate revealed significant differences between African and European Americans' LOC scores on the Rotter ($p = .004$) and on the fatalism factor of the Reid-Ware ($p = .043$). In comparison with normative data, European Americans demonstrated a more internal orientation with both scales, but African Americans scored more externally on both the Rotter and the Reid-Ware fatalism factor. The results suggest that internality varies by race and age, calling into question occupational therapists' use of LOC as a measure of normalcy.

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Title

Doing Occupational Therapy in a Community Mental Health Center

Presenters

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Key Words

community mental health, occupational therapy, qualitative research

Abstract

Nielson (1993) reported that in 1990 there were only 500 occupational therapists working in community mental health. This is 1.1% of all occupational therapists. She concluded that although we talk and write about the value of and need for community practice, we have not moved into the community because we don't understand our role there. She says we have a narrow vision of occupational therapy practice and we need to examine and describe community mental health occupational therapy.

This roundtable presentation reports on a preliminary study of an expert practitioner who has many years of experience working in a day treatment program of a community mental health center. The

study is a phenomenological examination of the meaning and significance of her professional life-world.

The purpose of phenomenological research is to understand the world through the description and analysis of first-hand human experience, as it is lived (Barrell et al, 1987). Often, only one individual, who is able to fully describe the phenomenon is studied (Hycner, 1985) and the researcher enters the world of the subject and lets events emerge. In this study the subject's experience was obtained through interview. Data will be presented in the language of the subject and description which shows the structure and meaning of her world of practice.

"Phenomenological research is an inexhaustible task of explication: of making explicit that which was lived implicitly, of reflecting upon the prereflective" (Barrell et al, 1987, pp451-2). Participants in this roundtable are invited to become part of the research process by reflecting upon the study; discussing it and comparing it to their own experiences. Discussion will include reflection upon themes of meaning; an analysis of clinical reasoning and a description of occupational therapy in community mental health.

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Title THE IMPACT OF A DIVERSE PSYCHIATRIC POPULATION ON PROGRAM DEVELOPMENT AND TRAINING

Presenters

Presenter: Victoria Schindler, MA, OTR, Director of Rehabilitation Services, Forensic Psychiatric Hospital, West Trenton, NJ and Adjunct Instructor, Dominican College of Blauvelt, Orangeburg, NJ
Presenter: Susan E. Connor, OTR, Supervisor of OT, Forensic Psychiatric Hospital and Lecturer, Department of OT, Thomas Jefferson University, Phila, PA
Presenter: Susan Griffiths, OTR, Senior OTR, Forensic Psychiatric Hospital and OT Consultant, The Medical Center at Princeton, Princeton, NJ

Key Words: Fieldwork Education, Occupational Therapy
Mental Health Occupational Therapy
Culture (Sociology)

Abstract

The patient population in our nation's state psychiatric facilities is progressively becoming more culturally diverse - more so than the general population (Adebimpe, 1994). Not only is this the case, but other cultural phenomena, such as the culture found among a prison/jail population (Toch, 1992 and Torrey, et al., 1992) and a homeless population (Herman, Struening and Barrow, 1993) are more pronounced due to the influx of these populations into the state psychiatric systems (Adebimpe, 1994, Toch, 1992, and Torrey, et al., 1992). All of this is in addition to the chronic, long term psychiatric population which, too, has its own cultural norms (Segal and VanderVoort, 1993).

The 1990 US Census indicates that 80% of our population is Caucasian, 12% African American and 9% Hispanic. The population in our state psychiatric facilities is 56% African American, 31% Caucasian and 13% Hispanic and other (Adebimpe, 1994). This indicates a disproportionate amount of African Americans, and to a lesser extent, Hispanics, in our state psychiatric facilities.

This paper is proposed because, although it deals with a difficult population, it is a culturally diverse population that needs to be included as part of the entire human community within the realm of Occupational Therapy.

In order to implement successful treatment, the total approach (including staff recruitment, program development and implementation, and student training) must be centered around the various cultural needs.

The occupational therapy program varies from individual treatment to higher level group treatment. The program utilizes a functional approach with age appropriate, meaningful activities to develop ADL skills, appropriate use of leisure time, coping mechanisms and appropriate social skills. With these goals, the Model of Human Occupation (Kielhofner, 1985) and Role Acquisition frame of reference (Mosey, 1986) are ideal for learning skills, habits and roles. Throughout all programs, activities and behaviors are incorporated to allow patients to gain understanding and respect for each other's culture. Holidays and traditions are celebrated regularly. A detailed description of the program, its theoretical base, and its use of cultural awareness as a normal, everyday component, will be presented.

Staff recruitment and student training also are addressed in this environment. Only 9.8% of students in OTR level programs and 15.3% of students in COTA programs (AOTA, 1994) are from ethnically diverse backgrounds. The ethnic diversity, prison and homeless cultures, and physical environment in this setting, can be a cultural shock to incoming staff and students. The interview, orientation and ongoing supervision process to assess and teach cultural awareness will be described. A newly developed nontraditional student fieldwork program (Crist, 1993) will also be discussed. The strength of peer support in this type of fieldwork is invaluable with a culturally diverse population.

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Title PSYCHIATRIC CLIENTS AS ACTIVITY VOLUNTEERS

Presenters

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Key Words Mental Disorders, Voluntary Workers, Purposeful Activity

Abstract The goal of many psychiatric day treatment programs is to discharge psychiatric clients to meaningful activity in the community. However, many of these individuals have difficulty making transitions, particularly into work-related activities. This may be due, in part, to difficulty with interpersonal skills, poor time management, an inability to organize, or difficulty in problem-solving (Jacobs, 1985). Other issues may include inadequate task skills, lack of appropriate challenge, lack of confidence or lack of structure upon graduation from highly structured day treatment programs. As a result, individuals may choose not to pursue competitive employment or job training, either because they are unable to fulfill job requirements, or because they wish to maintain their benefits. While these clients may be prime candidates for volunteer placement, they may be unable to successfully pursue this option due to lack of adequate support.

This presentation describes the Activity Volunteer Program at the Day Hospital of the Brooklyn Veterans Administration Medical Center. This program was initiated in November, 1993 by an interdisciplinary staff consisting of an occupational therapist, a social worker, two psychiatric nurses, and a recreation therapist who serves as an administrator of Voluntary Service.

The purpose of the volunteer program is to provide a supervised , supportive, in-hospital volunteer experience which promotes growth in interpersonal and task skills through the medium of purposeful activities. It is based on a Developmental Theory for Health and Rehabilitation which supports the use of growth and development experiences to remediate interruptions and gaps in development due to disease, injury or trauma (Llorens, 1976). It is anticipated that these experiences, which continue after graduation from the Day Hospital, will become a bridge to successful community reintegration.

This presentation discusses the two program tracks. In the General Track clients are assigned to regular volunteer positions in the hospital. In the Friendly Visiting track, psychiatric clients volunteer to visit patients on a medical unit of the hospital. The volunteers are trained by the occupational therapist to administer interest questionnaires, and to teach or provide hands-on craft and leisure activities. All volunteers attend a weekly peer support group to discuss their experiences with the multi-disciplinary staff. This program, which has successfully engaged clients in meaningful, ongoing activity, can serve as a model that can be replicated in other facilities.

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Title

LIMITED ENGLISH PROFICIENCY (LEP): IMPLICATIONS FOR PSYCHOSOCIAL OCCUPATIONAL THERAPY

Presenters

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Key Words

language
communication barriers
mental health occupational therapy

Abstract

Consumers and their families with Limited English Proficiency (LEP) present a major challenge to the occupational therapist who is primarily monolingual in English (Dymally-Alatorre, 1973). The barriers to communication between the therapist and consumer are particularly, but not exclusively, problematic in the area of psychosocial practice. Words are the primary instrument of both diagnosis and treatment in the care of persons with mental illness. Language barriers present an additional problem for the person with schizophrenia because both the process and content of thought are primarily communicated verbally (DSM-IV, 1994). When verbal communication is limited due to language barriers, behaviors and characteristics of the condition expressed through non-verbal activities take on primary importance that makes occupational therapy an especially important factor in treatment.

Key issues addressed in this two hour workshop are problems with communication and understanding between therapist and consumer, common language and cultural barriers, problems with misdiagnosis and misinterpretation of symptoms, and culturally appropriate treatment intervention for a Latino population (Marin & Marin, 1991.)

Learners will be able to describe specific communication problems between therapists and consumers with LEP; identify some key intercultural problems when planning treatment intervention; and exhibit sensitivity to the cultural context of treatment.

Challenges for both the beginning and the experienced therapist are working with an interpreter (Bamford, 1981), understanding the patterns of daily activities within a particular cultural context and understanding the community in which the consumer and his or her family function (Kleinman, 1980).

Because Latinos are the fastest growing group in the United States (Garcia & Montgomery, 1991), the importance of culturally appropriate activities to be used as treatment media will be addressed in relation to both occupational performance and treatment directed to family and community reintegration of Latino persons with mental illness and other conditions.

The workshop addresses inter-cultural communication and some suggestions to develop strategies for common ground. It presents a multicultural perspective on the identified communication problems and suggests several strategies of practice to address the needs of Latino consumers with LEP. An interactive, experiential, communication exercise is also included (Shoemaker & Shoemaker, 1991).

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Title Violence Prevention for Children and Families

Presenters

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Key Words

Social environment
Social development
Pediatric mental health

Abstract

Interpersonal violence is now recognized as a serious public health problem in the United States. Early predictors of delinquence and violence include behavior problems, low verbal ability, poor motor skill development, problem parenting practices, and adverse environmental circumstances (Buka and Earls, 1993). Research shows great promise for primary and secondary violence prevention approaches, suggesting that interventions should begin early, before aggressive behavior becomes a deeply ingrained method of problem solving (Spivak, Prothrow-Stith, & Hausman, 1988; Eron, 1980).

The dramatic impact of interpersonal violence on the physical and mental health of Americans affects occupational performance in many ways. Occupational therapists, with knowledge of how biopsychosocial factors influence health and performance, are in a position to help at-risk individuals develop the occupational performance skills needed to cope with life stressors in non-violent ways, live healthy lives, and be constructive community members.

This presentation will review relevant research on violence as a learned

behavior and on violence prevention efforts. Roles of OT in community based multi-disciplinary violence prevention programs will be outlined. This will be followed by a description of an intergenerational program for youth enrichment and violence prevention developed by faculty and students at Washington University Program in Occupational Therapy. Structured activities with group decisions, shared goals and active participation provide opportunities for children to learn prosocial behavior and alternatives to violence. Successes help build increasing confidence and self esteem. Problems help children learn ways to deal with frustration constructively, reset goals and adjust techniques. Adult feedback and support is provided during sessions, with ongoing attempts to involve parents who can carry out similar apporaches on a day to day basis.

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PEDIATRICS

Title Making It Easy: Adapting Home and School Environments

Presenters

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Key Words Inclusion
Environmental Adaptations
Sensorimotor Development

Abstract

As inclusion models develop and expand in education, the roles of teachers and therapists are changing. Teachers and therapists must assist in meeting the needs of a variety of students as the environment places new, ongoing demands on them. Parents are also under pressure trying to meet the needs of their children with and without disabilities. Therefore, collaboration with teachers, parents and students is necessary.

This workshop will focus on using a task analysis approach to assist the therapist in identifying the critial elements of the school and home environment that may be affecting a child. Based on the information identified, a variety of service delivery methods will be discussed using innovative planning. In addition, ways of analyzing the environments will be discussed in an attempt to incorporate therapeutic strategies and techniques into the child's daily routine.

Specific school and home environmental adaption strategies will include: analysis of the sensorimotor environment and the demands it places on a child, lesson planning and home activity guidelines, motivational factors, behavioral management guidelines, and calming and

alerting techniques.

School and home activities will focus on gross, fine and perceptual motor development that can be easily incorporated into the classroom or home routine. The activities may be added to the child's play, part of self-help skills, accomplished as chores or by assisting the parent or teacher in a daily task. The intent is that the activities become enjoyable for everyone involved and help foster a feeling of successful independence.

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Title

Sensory Process in At-Risk Infants

Presenters

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Key Words

Sensory Processing, Play, Infant Behavior

Abstract

This study examined the prevalence and types of sensory processing disorders and provided preliminary data regarding the impact of these disorders on play behavior. Two groups of children were studied: those at risk for developmental disorders because of prematurity, low birth weight or other pre and perinatal risk factors, and those born to mothers who are substance abusers. This study adds to an emerging body of knowledge which indicates that potential sequela for children born at risk or substance exposed includes poorly modulated state behavior, poor organizational abilities and disorganized play behavior (Als, 1986; Chasnoff, Griffith, Freuer and Murry, 1992; Young, Wallace and Garcia, 1992; Howard, Beckwith, Rodning and Kropenske, 1989). Although it has been difficult to quantify these subtle but significant deficits, they have been qualitatively documented (Young, Wallace and Garcia, 1992; Howard, Beckwith, Rodning and Kropenske, 1989; Anzalone, 1993 &1994). A link between dysfunction in sensory processing and these behaviors has been suggested, however, no studies have specifically examined this potential relationship (DeGangi et al, 1991; Stallings-Sahler 1993; Anzalone, 1993).

A sample of 50 children between the ages of 8 and 12 months were studied using a multi

method approach. The Test of Sensory Functions in Infants (DeGangi and Greenspan, 1989) was utilized to examine the frequency and types of sensory processing disorders. In addition the incidence of sensory processing disorders to specific prenatal, early developmental history and behavioral patterns were examined using a retrospective analysis of the medical chart and a sensory integration observation guide (adapted from Jirgal and Bouma, 1989). To examine the impact of sensory processing disorders on play behavior, video tape records were collected and thematically analyzed with videomicroanalysis used to investigate specific themes in depth. Overall themes of play and differences in play behaviors between a child with a sensory processing disorder and one without a sensory processing disorder were examined. Specific play themes that intersect with sensory processing were identified.

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Title

Understanding Family Members' Perspectives on Therapeutic Experiences

Presenters

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Key Words

Family; Professional-Patient Relations; Pediatric OT

Abstract

The movement towards family-centered care poses considerable challenges to practitioners trained in client-centered models of service delivery (e.g., McCollum & Thorp, 1988; Anderson & Hinojosa, 1984; Hanft & Humphry, 1988; Lawlor, 1990; and, Cada, E. & Lawlor, M., 1993). These challenges include the need for foundational shifts in our perceptions of the nature of the work in occupational therapy and in the processes we employ to develop therapeutic relationships. The successful implementation of family-centered care involves the development of an appreciation of the immense diversity in family life in our society and the ability to individually design services that are responsive to the unique strengths, concerns, and priorities of each family who seeks occupational therapy services.

Our understandings of characteristics of "best practices" in family-centered care and the meanings of illness and disability in family life are still evolving. However, we have identified strategies to promote better understandings of the perspectives of

family members through a series of federally funded research and training initiatives. The purposes of this session are to discuss research findings related to family perspectives and "daily dilemmas" in clinical practice; and to provide an experiential learning program designed to promote reflective practices in family-centered care.

The experiential component will incorporate the use of a series of three videos entitled "Forming Partnerships with Families." The course presenters will guide participants through a series of exercises that have been developed to maximize the participation of the audience in analyzing the course content. The materials have been piloted extensively with parents, therapists, and representatives of other disciplines who are expert in family-centered care delivery models. These video tapes were developed based on focus groups and narrative interview data gathered from families who have a child with an illness or disability. Our interpretation of these findings resulted in the identification of both family and therapeutic dilemmas that permeate practices with families. Not surprisingly, the experiences families described provide valuable perspectives and lessons about family life.

This project confirmed our assumptions that responsive family services are directly related to effectiveness of the interdisciplinary efforts. We will be discussing the types of partnerships that are successful for families and therapists.

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Title

Let's Play!: Basic Technology for Toddlers with Disabilities

Presenters

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Key Words

play development; child; technology

Abstract

Play is an integral part of the young child's life; it is the medium for early social and academic learning (Bergen, D., Gaynard, L. & Hausslein, E. (1988). In D. Bergen (Ed.), *Play: As a medium for learning and development: A handbook of theory and practice* (pp. 284-286). Portsmouth, NH: Heinemann). Infants and toddlers with significant disabilities are often limited in their play skills, resulting in serious difficulties with attainment of developmental skills. During the time when typically developing children are learning that their actions have an effect on their environment, and on individuals within their environment, children with significant physical, sensory and cognitive disabilities are learning that they are limited in their ability to produce action from, and interact with, the environment (Brinker, R. P., & Lewis, M. (1984). Discovering the competent handicapped infant: A process approach to assessment and intervention. *Topics in Early Childhood Special Education, 2*, 1-16). The long term effects of these deficits negatively impacts the

motivation to continue the attempt at play, interaction and communication (Jennings et al, (1985). Mastery motivation in young preschoolers. *Journal of the Division of Early Childhood, 9,* 162-169). While the need to find options that will promote play and development in this young population of individuals is apparent, innovative intervention ideas have been slow to develop.

The very early use of adaptive toys and switches has been suggested to be effective in forestalling the development of learned helplessness and learning deficits (Jennings et al, 1985). Technology may be the *only* means by which some significantly involved children can be engaged with the physical environment (Behrmann, M. M., Jones, J. K., & Wilds, M. (1989). Technology intervention for very young children with disabilities. *Infants and Young Children, 1,* 66-77.; Langley, M. B. (1990). A developmental approach to the use of toys for facilitation of environmental control. *Physical & Occupational Therapy in Pediatrics, 10,* 69-91; Swinth, Y., & Case-Smith, J. (1993). Assistive technology in early intervention: Theory and practice. In J. Case-Smith (Ed.), *Pediatric Occupational Therapy and Early Intervention.* Boston: Andover Medical Publishers; Wachs, T. D., & Gruen, G. (1982). *Early experience and human development.* New York: Plenum Press). Unfortunately for many parents and service providers, the "what" and "how-to's" of either high- or low-tech assistive technology for very young children, as well as the application of technology within daily living environments, have not been forthcoming.

This workshop is designed to begin the unraveling of these issues in the application of low-tech assistive technology to the birth to three year old population of children with disabilities and their families. We will address the importance of play in development for children with and without disabilities, as well as the use of toys, switches and interfaces, adaptations, and positioning to promote play for children with disabilities, and for their families. Furthermore, issues such as incorporating play and AT into daily, natural, environments and routines will be discussed. Finally, we will present a parent driven, family focused model being used successfully in our current project.

Title

OT/PT Team Perspective on Family Education in Multicultural NICU

Presenters

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Key Words

NICU, multicultural, OT/PT team, Family Education

Abstract

The rapidly changing NICU environment bombards caregivers with predischarge information relevant to the developmental needs of their premature infant. There is a need for early interdisciplinary team intervention which recognizes the multicultural diversity of these caregivers. This presentation plans to provide the audience with a discussion of the complexities of family/therapist relationships and their effect on the educational process that occurs in a stressful NICU setting. Objectives of the presentation include:

- Discussion of the use of multicultural learning tools in individualized educational sessions.
- Defining need for structured intervention programs for special need infants.
- Description of benefits of OT/PT NICU team approach to family education.

The presenter will utilize case study methodology and provide written materials for audience reference. The first case will discuss alternative approaches to family education. Videography was used to demonstrate ROM/positioning/handling for a premature infant with Trisomy 18 whose parents possessed limited formal education.

Another case acknowledges the difficulties encountered in family education

efforts directed towards a 16yo mother with pregnancy history of crack cocaine use, ETOH abuse and smoking who interacted poorly with her premature infant.

The third case discusses educational issues influenced by parental anxiety which can escalate when caring for a premature infant with cerebral palsy.

The final case illustrates another aspect of OT intervention when educational goals are directed towards other health care professionals as in the case of an HIV positive premature infant with an absent caregiver.

Current research in the area of family centered intervention supports the need for early caregiver education with special need premature infants. Occupational therapy as a member of an interdisciplinary NICU team can provide a unique opportunity for families to actively participate in their child's developmental care.

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Title

Caregiver-infant Interactions in Infants Prenatally Exposed to Drugs

Presenters

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Key Words

Infant, High Risk
Substance Abuse
Parent-Child Relations

Abstract

While there are numerous studies on developmental outcomes in infants with prenatal exposure to drugs or alcohol, few studies have investigated the effect of substance abuse on parenting. The purpose of this pilot study was to describe the quality of caregiver-infant interactions during feeding and play in an ethnically diverse sample of infants with prenatal exposure to drugs or alcohol.

A subsample of 24 caregiver-infant dyads were selected from a group of subjects participating in a large intervention project in Seattle, Washington. The MOMS Project, funded by the National Institute on Drug Abuse, aims to improve the lives of chemically-dependent women and their children. Forty-six percent of the caregivers in the subsample were African-American; 42% were European-American; 4% were Native American; and 8% were multiracial. The mean caregiver age was 26.96 years (SD=4.16). Sixty-two percent of the sample reported having a partner who was helping raise the infant and 38% reported no partner. Twenty-nine percent of the mothers had less than high school education, 42% had completed high school or GED, and 29% had completed some college.

The Chatoor Feeding and Play Scales were used to rate videotaped segments of caregiver-infant interactions. These interactions were videotaped during a 2 1/2 hour visit in which the occupational therapist administered the Bayley Scales of Infant Development (BSID), the Movement Assessment of Infants Screening Test (MAIST), an unstructured play time, the NCAST Teaching Scale, the Parenting Stress Index (PSI), and a caregiver interview.

The infants in this pilot study obtained a mean score of 106.42 (SD=11.58) on the Mental Index and a mean score of 104.04 (SD=12.96) on the Psychomotor Index of the BSID. On the MAIST the mean risk score was 2.50 (SD=2.47). Thirty-eight percent of the sample obtained a risk score of 3 or greater, indicating a need for further evaluation of neuromotor development. None of the caregivers scored in the risk range on the PSI. Forty-one percent of the dyads scored in the risk range on the NCAST Teaching Scale.

The sample's performance on the Chatoor Feeding and Play Scales compared to the test norms suggest no clinical concerns regarding interactions during feeding, however significant concerns were found on two of the four play subscales (maternal unresponsiveness to infant's needs and dyadic conflict). Further analysis was done on those dyads who obtained risk scores of greater than -1.0 standard deviation on two or more subtests of the Chatoor Feeding and Play Scales. No significant differences were found between the "interaction at-risk" group (n=11) and "interaction no risk" group (n=13) on variables including caregiver age, caregiver ethnicity, number of days of drug treatment, and the PSI. However, the "interaction at-risk" group performed significantly worse on the "mother's sensitivity to infant's cues" subtest of the NCAST Teaching Scale [F(1,22)=8.55; p=.008].

While these results must be interpreted with caution and cannot be generalized to other caregiver-infant dyads affected by substance abuse, this sample's performance on some measures were within normal limits. The Chatoor Feeding and Play Scales may be one instrument useful in screening for "at-risk" caregiver-infant interactions in families affected by substance abuse.

Title

The ADA and Children With Disabilities

Presenters

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Key Words

American's With Disabilities Act
Child

Abstract

The American's With Disabilities Act of 1990 (ADA) offers significant advancement in civil rights for individuals with disabilities, including children with disabilities. The law prohibits discrimination against these individuals and those who have a known association or relationship with them. The ADA's titles address non-discrimination with regard to employment, public services and accommodations, and telecommunications.

Occupational therapists have the obligation to educate families and serve as advocates for children with disabilities. To do this effectively the occupational therapist must have an understanding of the ADA as it protects these children and as it relates to other federal mandates protecting them (eg. The Rehabilitation Act of 1973 and the Individuals with Disabilities Education Act).

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Title

Adolescents With HIV: Vocational Issues

Presenters

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Key Words

1) Adolescence
2) HIV Infection
3) Vocational Guidance

Abstract

Although HIV infection among adolescents is increasing at a disturbing rate, limited epidemiological and medical research has been done to date due to socioeconomic and legal sensitivities. The National Institutes of Health is setting up a research study for adolescents including minority youth from its adjacent urban area. O.T.'s research role will be exploration of vocational interests and choice in adolescents with a life-threatening illness (HIV) who are, nonetheless, surviving longer due to increasingly sophisticated and effective medical intervention.

The purpose of this three-year study will be to:
1. Determine the current activity level of adolescents
2. Determine how adolescents feel about their activities and about themselves
3. Assess how adolescents see the future in terms of their activities, vocational interests, and vocational choice
4. Identify additional resources adolescents desire in order to help prepare themselves for a vocational future
5. Compare the responses of HIV-infected adolescents to reports in the literature from a comparable group of adolescent cancer survivors

Assessment Tools:
1. One Day Activity Chart
2. O.T. Functional Screening Tool
3. Modified Interest Checklist
4. Role Checklist

Subjects: 50 adolescents with HIV disease

Frequency of Administration of Assessments: Baseline, 6 months, and 12 months, using an interview format

How data will be analyzed: By use of non-parametric statistical techniques

How research relates to OT: Analysis of data will provide insight into the vocational choice process of adolescents with HIV disease. The knowledge will make the OT profession more effective in providing relevant guidance to the HIV infected adolescent population as they prepare to become vocational beings.

The model of care being delivered to infected adolescents including minority urban populations and some homeless youth who have not traditionally been studied by this research institution has national applicability as it brings up racial and cultural sensitivities in treatment and research situations which are community-based but academically developed and sponsored.

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Title

Videotape Protocol for Assessing Pervasive Multiple Impairments

Presenters

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Key Words

Child Development Disorders
Assessment Process, Occupational Therapy
Problem Identification

Abstract

Occupational therapists who serve clients with multiple impairments nearly always work as part of a team, and yet assessments generated by team members may be fragmented and based on very different samples of behavior. One tool for helping team members to focus on specific, as well as holistic issues, is the use of a videotape analysis using a common protocol. A videotape protocol serves to help team members observe multiple factors that contribute to occupational behavior, including skills in the domains of cognition, physical/motor development, psychosocial development, and spontaneous involvement in work/play activity.

Construction of this protocol was based on two primary assumptions: (I) the process of assessment is usually restricted to judgments and answers about "what is known" rather than active questioning about what is not known, and (2) the perspective we take drives the questions we ask, and (3) multiple perspectives result in richer, more accurate assessments.

The following questions were developed to facilitate discussion among team members after viewing a sample of behavior on videotape.

Videotape Assessment Protocol (Stone, 1994)

1. What questions do you have about this individual? That is, what would you like to know more about?

2. Describe an incident which you think exemplifies engagement, or lack of engagement, in meaningful activity.

3. What behaviors or skills did you observe that enhanced ability to engage in this activity?

4. What behaviors or skills did you observe that disrupted or interfered with ability to engage in this activity?

5. Label the questions you wrote for item 1 according to the area of functioning you think they represent:

PM physical motor **COG** cognitive **WP** work/play **PS** psycho/social

6. If you did not write a question that was labeled with one of these four codes, do so now in the space below.

7. Choose two questions that you have labeled with different codes. Discuss how these questions are related.

This protocol is intended to be used as a supplemental assessment. The prime benefit of this tool may be in helping occupational therapists and other team members to consider processes that contribute to occupational behavior when writing performance goals.

Analyses conducted during construction of this instrument, reveal that a condition in which subjects devised their own questions and then organized their questions under previously defined categories was more effective than conditions in which subjects either initially wrote questions under previously identified categories or wrote questions but did not reflect upon them in order to group them within domains of functioning. It appears that unrestrained questioning followed by rational analysis are important components of the process of defining client-related concerns.

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Title Transition Program Evaluation for Adolescents in Special Education

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Key Words occupational therapy • follow-up • transition

Abstract

An Independent Living Skills Transition (ILST) Center was established in 1984 to facilitate the transition of adolescents with disabilities from high school to adult roles and community living. This program encouraged student achievement of self-determined goals based on their own interests, abilities, and motivations in one or more of these areas: daily living skills, social communication, leisure/recreational skills (Jackson, et al., 1990). The purpose of this study was to provide multifaceted follow-up information on the participants of an occupational therapy-based transition program for adolescents.

Among the few published follow-up studies on transition programs, the vast majority use employment as the only measurable outcome of successful transition. Researchers have consistently identified the need for more follow-up research that focuses not only on employment status, but also on other dimensions indicative of successful transition.

Dimensions such as: personal and social networks, leisure and recreational pursuits, and independent living status (Edgar, 1985, Halpern, 1985).

Data were gathered through a five to twenty minute telephone survey on twenty-two subjects one to five years after participation in the transition program. A telephone survey was selected for data collection because it facilitated participation, provided immediate data retrieval, increased the control over the speed of implementation, is appropriate for specialized sub populations, and is cost efficient (Frey, 1989).

A correlational research design was used to identify relationships between variables. Data were gathered in the following areas: age, sex, race, duration in the ILST program, special education category, school, employment, volunteer activities, living arrangement, socialization, and life satisfaction. Both an Analysis of Variance (ANOVA) and two-tailed *t* tests were used. Descriptive information was included.

The results of this study found that success in one area of transition was independent of success in other areas. This study is relevant to occupational therapy because findings provide information to support the value of multifaceted occupational therapy-based transition programs and to acknowledge the expertise of occupational therapists when developing students transition planning objectives, establishing transition programs, and implementing transition services.

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Title

A Competence Oriented Approach to Improve Feeding Behaviors

Presenters

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Key Words

Pediatrics, Feeding Intervention

Abstract

The competence oriented approach focuses on enhancing and expanding the infant's/child's current feeding behaviors. This approach does not ignore problematic feeding behaviors, but the focus of intervention is on increasing the frequency, variability, and complexity of the infant's/child's current feeding skills. This approach includes a comprehensive assessment of feeding behaviors but instead of just identifying the deficits, this approach identifies feeding behaviors that are present or emerging. The intervention plan is developed with the family to increase the occurence of these emerging skills instead of a treatment plan that focuses on abnormal componenets of feeding.

This approach is contrasted with the traditional medical model of a problem-oriented approach. The traditional problem-oriented approach focuses on the individual's disability and how the disability impacts function (Trombly, 1989).

This problem-oriented approach has been criticized for it's bias towards the western medical model and it's limited flexibility towards other cultural views (Barney, 1991; Dillard, et al, 1992). This limitation with the problem-oriented approach is particularly seen when working with families. Fundamental to family centered intervention is the therapist's need to not only recognize, but also enhance, the families inherent strengths and competencies (Hanft, 1988; Humphry, et al, 1993; Winkler, et al, 1983).

The unique advantage the competence oriented approach offers the occupational therapist is the focus on the child's competent feeding skills and the identification of the inherent family strengths. This necessitates an appreciation of family competencies regardless of culture or composition. The approach provides a framework for the occupational therapist to develop a holistic intervention plan with the ultimate goal of enhanced competent feeding behaviors (Morris, 1978; Schkade & Schultz, 1992; Schultz & Schkade, 1992).

This approach views feeding behaviors from three different domains of sensorimotor perfromance, cognitive skills, and psychosocial interaction. The evaluation identifies the unique strengths/competencies of the child in all three domains. Superimposed onto the evaluation process is the parent's report of perceived strengths/competencies in these domains as related to feeding the child. The intervention program is developed, with the parents, focusing on enhancing the emerging feeding behaviors in the three domains.

The rationale for this approach is derived from the understanding that although an infant or child may exhibit feeding problems, the impact of this deficit may be minimized by enhancing the child's strengths.

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Title Motor and Language Team to meet diverse student needs

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Key Words collaboration, teamwork, transdisciplinary approach

Abstract

Sherry Reed, MBA, OTR and Sarah Higgins, M.A., CCC-SLP are public school therapists who successfully utilized a team approach for two years. They worked in an elementary school customizing their treatment approach to individual classrooms. The positive results of their teamwork was evident to teachers and parents who saw significant growth in the students during this period of collaboration.

Today's school based therapists encounter many obstacles in effecting therapeutic change in the children they serve. Examples of such obstacles are:

1. Children do not have the foundation skills in place in order to meet the academic challenges they encounter in the classroom.
2. Therapists have limited time and resources to intervene and make significant and lasting changes in the functionality of children at school.
3. The familiar way of providing services to children singularly does not always provide the carryover into the classrooms.

Reed and Higgins felt that school-based therapists need options to better serve children with significant and diverse needs. In their experience, collaboration and team treating was one viable model to consider when serving these children. Their use of the team approach created high-energy therapy sessions that encouraged increased learning for both the students and therapists. The therapists used each other as sounding boards to develop creative treatment interventions and they provided support to each other during trying times.

The combination of speech and motor in team treating is natural as both professions believe in the acquisition of developing foundation skills before attempting to master higher level skills, in the repetition of quality movement, in functionality, independence, and taking a holistic approach to problem solving.

Their presentation discussed:
1. The benefit of working with a professional from another discipline;
2. The type of personalities that make for a successful collaboration;
3. How to use collaborative goal setting;
4. When and how to plan treatment sessions;
5. The different teaching models available for use by collaborative team;
6. Possible roles the classroom teacher can play in the collaborative process;
7. Trouble-shooting possible problems the therapists may encounter; and
8. How to establish needs-based activities.

Title

Executive Dysfunction in Children with Attention Deficit Disorder

Presenters

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Key Words

Attention Deficit, Executive Functioning, Compensatory Skills

Abstract

Attention Deficit Disorder (ADD) represents the most common reason for school underachievement. Approximately 3% of all school age children are affected exhibiting behaviors of decreased concentration, distractibility, performance inconsistency and difficulty with self monitoring. Denckla (1991) has noted that children with ADD have areas of "dysfunction" in executive functioning which is a term used to describe higher level cognitive skills other than intelligence, housed in the frontal lobe region of the brain. Children with "executive dysfunction" have problems planning, organizing, and managing time and space, which are skills needed for successful academic performance.

Emerging research in developmental neuropsychology suggests that there is a developmental sequence involving executive functioning skills that emerge in infancy and early childhood. Bruner (1973) found evidence of anticipation and planning in infants, as well as impulse control, self-monitoring, and goal attainment in toddlers. Additional studies suggest a possible maturational lag in prefrontal lobe functioning among children with ADD (Chelune, Ferguson, Koon, & Dickey, 1986).

Occupational therapists encounter children with attention deficits in a variety of practice settings. Therapists often encounter problems determining appropriate evaluation and treatment approaches with proven validity. Although many evaluations have documented sensitivity to prefrontal lobe functioning in adults, the reliability and validity of these tools as measures of executive functioning in children have not been established.

The authors are currently investigating the test-retest reliability and the construct validity of several tools that are measures of executive functioning in adults. Examples of measures currently used with adults and hypothesized to be sensitive to frontal functioning in children are the Tinkertoy Test, Symbol Digit Modalities Test, Purdue Pegboard, and Wisconsin Card Sorting Test. A key theme in this investigation of test instruments is that measures used to detect executive functions must be developmentally appropriate.

Once measures that are sensitive to executive functioning in children are established, developmentally appropriate interventions can be investigated. Although cognitive-behavioral interventions have been effective in adult populations with frontal lobe damage, inconsistent findings persist throughout the research literature on using these strategies with children with attention deficits. Cognitive-behavioral intervention is appealing for occupational therapists because it addresses core problems of impulse control, higher order problem solving, and self-regulation needed for self-care, academic work, and leisure pursuits.

The authors are working towards establishing quantitative measures that are sensitive to measuring executive functioning in children with attention deficits, and developing interventions that have proven effectiveness for this population.

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Title

Evaluation Tools for the Assessment of Children's Perceptual Skills

Presenters

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Key Words

Assessment, Visual Perceptions, Computers

Abstract

The purpose of the institute is to provide occupational therapists with the tools to make educated choices in the process of evaluating perceptual skills of children, utilizing conventional and computer-based assessment tools.

The adoption of federal mandates has resulted in increased numbers of children and families eligible for services and a concomitant increase in the number of health professionals to provide service. Therapists who work in the community in school systems and/or early intervention programs need advanced knowledge and skills that can be applied to children with a broad range of disabilities.

Perceptual deficits are common in many diagnostic groups with whom occupational therapists work and are a frequent factor impeding functional performance Occupational therapists evaluate, train and remediate visual perceptual skills. Accurate assessment of visual perceptual skill is necessary for appropriate intervention.

The introduction of computer technology to occupational therapy provides Occupational Therapists with new tools that bring to the field exciting opportunities but also a new set of questions. Questions such as how computers relate to our existing frame of references, how they integrate in our practice, what are the skills that we are assessing, and is there any transition from the information extracted on the students through the computer to other areas? How does the computer correlate with conventional assessment tools? In order to answer this question Occupational Therapists need a thorough understanding of the theoretical frame of reference pertaining to perceptual skills, and also the assets and limitations of the conventional and the computer-based assessment tools.

This presentation will provide theoretical background pertaining to perceptual skills and guidelines to assist the participants of the workshop in the clinical reasoning process of applying conventional and computer based assessment tools to the evaluation of perceptual and cognitive skills.

Objectives

1. Increase therapists knowledge of current theories pertaining to perceptual skills as they relate to children with various disabilities.
2. Analyze and evaluate conventional assessment tools for measuring visual perception skills.
3. Familiarize with the state-of-the-art computer-based perceptual assessment tools.
4. Identify criteria for evaluation of computer-based assessment tools.
5. Integrate conventional and computer-based assessment tools in the process of evaluation of children with perceptual deficits.

Methods

The program will include lecture, demonstration, hands on manipulation and discussion. The lecture will be supported by audio-visuals such as video, slides, computer presentation and overhead transparencies. A discussion will follow the lecture and demonstration. Handouts will be provided with descriptions and sources of each product demonstrated.

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Title

Play of African-American and Nigerian Preschool Children

Presenters

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Key Words

Play, Culture, Children

Abstract

Florey characterized play as one of the most visible and commonplace phenomena of Childhood (1971). Lloren's classic article on Black culture and child development (1971) emphasized the need to consider diverse cultural backgrounds of children. Available assessments of play (Kielhofner & Barris, 1984) may not capture all of the differences in play behaviors of children from diverse backgrounds.

The purposes of this study were:
- a) to identify similarities and differences in free play of 3-4 year old African-American and Nigerian children.
- b) to identify similarities and differences in play of these children based on gender.
- c) to identify factors in family heritage and childrearing practices of parents that may chape development of play.

Research Design/Plan

This descriptive design combined quantitative information gathered through structured observation of preschool chidlren's free play with qualitative information gathered through interviews with parents.

Ten African-American and ten Nigerian Preschool children (5 males/5 female per group) were observed for 30 minutes (per child) during free play. The formal and informalobservations were recorded on the Preschool Play Scale (Bledsoe & Shepard, 1982) Semistructured interview with parents yielded qualitative data on familyheritage, cultural beliefs and child-rearing practices.

The differences in the category and play age scores of the Preschool Play Scale were examined using independent and tests. African Americans scored significantly higher on gross motor activity while Nigerians scored significantly higher on purpose and attention. There were no significant differences between males and females. Qualitative data revealed Nigerian parent's efforts to pass on their heritage to their children were more conscious than those of African American parents. Differences in childrearing beliefs occured in relative emphasis on values that parents should instill in children and reported disciplinary practices.

Conclusions

Play is a fundamental aspect of all developmental theories in Occupational Therapy. After heavy emphasis on play by Reilly and her students (1974), interest in play is growing among scholars and practitioners (Bundy, 1993). Increased awareness of cultural differences can help us understand what is universal and what is culture specific in play. This study has important implications for therapists working in early intervention or school programs can utilize this perspective in working with children and families from various cultural backgrounds. Implications for research suggest the importnace of studying play not as an abstract category of behavior, but also as forms of activities for education include the importance of teaching students to see occupations in a cultural context and to recognize the special challenges of learning to function in more than one culture.

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Title

Time-Use and Well-Being for Mexican-American Mothers Parenting Disabled Children

Presenters

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Key Words

Cultural Diversity, Parenting, Qualitative Research

Abstract

So-called minorities are making up larger portions of the U.S. population. For example, in California, and especially Los Angeles, individuals of Mexican heritage are 28% of the state's and 40% of the city's population and are projected to be the majority by the turn of the century (Brownstein & Simon, 1993). Occupational therapy practice needs to expand its knowledge regarding cultural diversity. Federal laws require professionals to work cooperatively with parents in early intervention and school based practice in ways which are respectful and sensitive to the human issues.

Occupational therapy theory has linked well-being and the orchestration of a daily rounds of activities. A current trend is to examine how minor stressors or hassles influence an individual's expression of well-being (Kanner et al., 1981; Chamberlain & Zika, 1990; Reich & Zautra, 1983). These researchers suggest that the daily mundane events have power in predicting well-being and adaptational outcomes (Kanner et al., 1981); and are salient in well-being and mental health (Chamberlain & Zika, 1990).

This paper will present a qualitative research study which examined the subjective well-being, time-management, and hassles as related to parenting for Mexican-American mothers of children with severe disabilities. Mothers participated in in-depth interviews with the investigator and a translator discussing their time-use, well-being and child care; were observed during an entire round of daily activities; and completed a Hassle index (Kanner et al., 1981), and well-being scale (Juster, et al., 1988). Data from interviews was transcribed and analyzed along with field notes of daily routines using a symbolic interactionism approach. Tentative findings suggest that mothers attempt to create a meaningful round of family activities, that once the mothers feel mastery over the child's care and can construct a reasonable routine stress decreases, and that mothers make many choices about routine which may be costly to themselves but which are based on maternal thinking (Ruddick, 1989).

The presentation will describe current literature (on daily rounds of activity and time use and their relation to well-being; and the ecocultural approach and mothering a disabled child), outline the study methodology, present research results and describe the application of findings to practice with this ethnic group.

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Ruddick, S. (1989). *Maternal thinking: Toward a politics of peace*. Boston: Beacon.

Title

Cross-cultural occupational therapy: Building on clients' adaptive strategies.

Presenters

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Key Words

CULTURE (ANTHROPOLOGY); INTERVENTION PROCESS, OCCUPATIONAL THERAPY

Abstract

Occupational therapists are working with diverse populations in increasing numbers, and many are volunteering their specialized skills in international settings. The purpose of this paper was to present applied anthropological concepts, and discuss strategies, that occupational therapists working in cross-cultural or other diverse settings can use to increase the successful implementation of their treatment programs. Occupational therapists may have an advantage as cross-cultural clinicians because they are professionally socialized to value the importance of personal meaning in choice of occupations and the adaptive capabilities of the client; additionally, the profession increasingly emphasizes a view of the individual as a member of social and cultural groups (Krefting and Krefting 1991, Masagatani 1993, Mattingly 1993).

This case study describes the author's experience as an occupational therapist working in a non-governmental organization serving abandoned and malnourished children in Peru. Focusing on the developmental needs of the children was an essential aspect of the clinical role. However, an initial period of ethnographic research was incorporated into the intervention program in order to determine which child care practices were adaptive (LeVine, 1988) and how typical, culturally-valued activities (i.e. singing, play) contributed to child development and adult/child interaction within this cultural setting. This preliminary cultural analysis enabled the

"anthropologist-clinician" (Weidman, 1982) to develop a program that built on caregivers' strengths, thus making ongoing implementation more successful.

The emic-etic approach (Kaplan &Manners, 1972, Pelto & Pelto, 1978) to cultural analysis was used in order to acquire a comprehensive understanding of clients' needs and expectations. Research methods included personal interviews and observation, with the occupational therapist assuming the role of participant-observer (Bernard, 1988). Implications of the study include suggestions for using these approaches as part of the occupational therapy process and a discussion of how these strategies could be used in working with diverse populations in the United States.

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Title

The Nature and Relative Prevalence of Sensory Defensiveness

Presenters

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Key Words

Sensory defensiveness; developmental disabilities

Abstract

Although there are numerous theoretical discussions of the nature of tactile defensiveness and other types of sensory defensiveness (Ayres, 1972; Royeen & Lane, 1991), there is little empirical data about these phenomena (Baranek & Berkson, 1994). Clinicians speculate that these phenomena are prevalent in persons with developmental disabilities (DD), although no estimates of prevalence are currently available.

This study investigates the relative prevalence of sensory defensiveness in a large sample of adults (n=158) and children (n=88) with DD. Using a survey method, we asked about various kinds of stereotypical and unusual behaviors that persons with DD display. From these 54 items, 6 items were selected that we thought represented types of sensory (i.e., tactile, auditory, visual) defensiveness.

Two informants who knew each participant well, responded to the questionnaire noting whether or not each behavior was present, and how much it interfered with adaptation. Inter-rater reliabilities (Cohen's Kappa) were computed. The relative prevalence of each behavior was then calculated utilizing both a loose (one-rater) and a stringent (two-rater agreement) criterion. Prevalence estimates in our sample ranged from 3% to 34%, dependent upon on the

criterion used as well as the particular defensive behavior. Developmental differences within the sample emerged as well, with children displaying a higher prevalence of "hypersensitivity" (Chi-square $p<.05$).

Additionally, the relationships among the various types of sensory defensive behaviors were analyzed using Pearson correlations. These analyses resulted in several significant relationships. Most notably, "avoiding being touched" was related to "being bothered by toothbrushing/facewashing" ($r=.33$) and to "hypersensitivity" ($r=.26$). "Upset by noise" was related to "avoiding certain clothing" ($r=.26$). "Food aversions" was not related to other items.

The above results suggest that sensory defensiveness is not a unitary phenomenon. However, several relationships do exist among the items surveyed, suggesting some overlap within the construct. These findings elucidate the complexity of the concept of sensory defensiveness and have implications for OT assessment and treatment.

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Title School-Based Occupational Therapy: An Ecological Model

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Key Words

Education, special, public schools

Abstract The current direction of occupational therapy is toward community-based practice. Accompanying this movement is a necessary shift from clinical approaches to patient care to integrating services within community settings such as schools. Observation, assessment and treatment of an individual within real contexts adds new dimensions and set of challenges to practice.

School-based practice is a large and growing arena for occupational therapists. Federal laws require that handicapped preschoolers and students receive occupational therapy services when necessary to benefit from early intervention and educational services. Increasing numbers of therapists are needed in school systems to comply with federal and state mandates. These non-clinical settings compel therapists to use ecological approaches appropriate to the classroom. Currently, very few models, assessment procedures and treatment strategies address school-based oocupational therapy practice using ecological constucts.

This presentation will present an ecological model for school-based practice, guidelines for occupational therapy's

unique contribution in the educational environment, an observation tool for classroom assessment, video case studies illustrating the model, strategies for communicating knowledge with educational team members, and guidelines for service provision. Participants will learn through lecture, overheads, video case study, handouts and small group discussion. As an exercise in clinical reasoning, attendees will view a case-vignette and apply the concepts of the model presented.
Learning objectives for this session include:
1-Attendees will learn a method of observation and assessment of the student within the educational context
2-Participants will be able to identify the occupational therapist's unique contributions to the multidisciplinary team in the educational setting
3-Attendees will learn strategies for treatment provision within the school environment (direct service, consultation, integrated service delivery, training of other staff)

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Title

Animal Assisted Therapy as a Modality with Children

Presenters

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Key Words

Animal Assistants, spinal cord injury, children

Abstract

Children with spinal cord injuries can be a challenging population to treat successfully, especially those patients who are in the early stages of their rehabilitation. They cannot foresee the future in order to realize how activities in therapy relate to specific long term goals. In addition, the normal stages of adjustment including denial, depression, anger and fear may also contribute to the child's decreased involvement in the therapy program and slower progress towards goal achievement. It becomes imperative that the therapist provide activities that are creative and fun in order to keep the patient's attention.

Animal Assistants are being used as a modality in the treatment of spinal cord injured children. As this population's primary occupations are play and school, the model of Human Occupation is applicable. The animals motivate the patient to participate in playful activities that are designed to work on short term goals such as strength, endurance and using adapted equipment in order to return to school. The physical and psychological ramifications of a spinal cord injury have been surpassed through the use of animal assistants. Use of these

animals have shown to improve motivation, socialization, self-esteem, strength, endurance, balance, the use of adapted equipment, and the awareness of responsibility for self care and activities of daily living.

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Title Sensorimotor Treatment in Therapeutic Riding: A Case Study

Presenters

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Key Words

Case Study
Animal Therapy
Sensory Motor Integration

Abstract

Opportunities for occupational therapists to develop new and innovative services in nontraditional settings and among diverse populations is becoming a growing trend. The optimal environment for supporting functional independence is one that challenges present competence. This challenge is achieved by increasing the environmental demands above the client's functional level. The purpose is to engage the client in an occupation that is difficult enough to focus attention and set into action the sequence of thinking, doing and evaluating that leads to competence. This presentation will demonstrate that the complex, novel modality and environment of the therapeutic riding program provides the optimal challenge and level of arousal necessary to develop competence which carries over into a number of occupational settings including the home, school and play environments.

Horseback riding is a goal-directed purposeful activity which involves active involvement by the participant. The treatment approach increases motivation and is ideal for developing skills in the sensorimotor, cognitive and psychosocial areas necessary for successful occupational performance.

This paper illustrated by slides, presents the treatment approach and clinical changes exhibited by a six year old child with sensorimotor problems after nine months of weekly occupational therapy treatment sessions at an accredited operating center of the North American Riding for the Handicapped Association (NARHA).

Pretest and post-treatment test results are compared and analyzed to measure if significant improvements were achieved. Frequency and duration of treatment sessions as well as specific activities and environmental adaptations are illustrated. The child's responses during treatment are compared to carry-over in other settings. Recommendations based on results of post-testing are described.

This presentation provides a rationale for the use of therapeutic riding as an effective occupational therapy approach in the treatment of sensorimotor dysfunction.

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PHYSICAL DISABILITIES

Title

Seating And Positioning For Individuals With Developmental Disabilities

Presenters

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Key Words

Mental Retardation
Seating and Positioning
Neuromuscular Disorders

Abstract

With the development of new technology and availability of funding, provision of individualized seating and mobility systems is becoming a recognized specialty area of occupational therapy practice. This technology is also providing the means for inclusion of people with developmental disabilities into diverse community living environments. Rapid advances in seating technology make it imperative for therapists to remain current in this evolving area. Appropriate seating greatly facilitates the functional abilities of individuals with multiple disabilities and their access to community participation. Persons with severe developmental disability frequently have neurological impairments which affect muscle tone, movement, functional skills and posture which can result in skeletal deformities and abnormalities of internal structures. Additionally, persons with neurological impairment are more likely to have more serious complications of disease or illness than individuals with other types of disabilities. Positioning can be critical as a stabilizing influence for individuals with aberrations of muscle tone, poor postural integrity, and low endurance. Appropriate seating can impact serious medical conditions through proper body alignment and through its affect on primitive reflexes.

Major areas to be covered by this workshop include philosophy and application of techniques for providing "successful " seating and positioning systems for individuals with severe handicapping conditions. This approach requires attention to physical, functional, medical, environmental, cosmetic, and financial factors. Physical problems encountered in seating individuals with multiple disabilities include abnormal muscle tone, primitive reflexes, complex medical conditions, skeletal deformities, poor muscle strength, and small ranges of functional movement. Functional problems include limited transfer skills, poorly designed living and work environments, the individual's need for comfort and rest while maintaining optimal positioning for mobility and work, and cosmetic factors which can dramatically affect self esteem and treatment by others.

Included is a discussion of fit and design of seating systems, use of multiple positions in space, contouring, application of aesthetic principles and modification of existing equipment. Solutions to problems caused by medical conditions which can be managed through use of specialized systems and components will be described.

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Title

Developing an Attitude-Based Prevention Program

Presenters

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Key Words

Prevention
Attitude
Injury

Abstract

Occupational therapists are well versed in the area of "Process." Effective rehabilitation is a seamless series of steps that assist a person as they progress through the stages of recovery.

In industry, the concept of process is also well understood. In this case, as it relates to the manufacturing of product. In industry, an idea takes shape in the research and development department, moves to engineering for design, goes out into the plant for fabrication, and then to the loading dock for shipping. Without one of these pieces the product won't make it to the marketplace. The concept of process is less understood by industry in the area of injury prevention. Injury prevention, for years, has been presented to industry as back schools and videos. Medical management has been defined as bed rest and medication. Even today, many companies view injury prevention as an adjustable chair or a wrist rest. Companies didn't choose to view injury prevention and management as single, one dimensional events. They only responded to how these items were presented to them. It is time to change the presentation.

The problem lies in the fundamental difference between a program and a process; the difference between a single event and an ongoing commitment to growth and change. The driving force

behind commitment is attitude. For a process to be successful it must take into consideration the attitudes of all involved. A program or single event does not take the time or create the energy to have a positive, longstanding impact. As a result, the following attitudes towards injury prevention have developed.

•Management:
"It costs too much"
"It won't work"
"We tried it before"
"The employees are fakers "

•Supervisors:
"It takes too much time away from production"
"Management isn't behind this and it will be gone in a month like every other program this company ever started "

•Employees:
"If we wait long enough this program will go away"
"The only reason management is doing this is because our injuries cost too much, not because they care about us"
"The company has insurance to cover injuries, they don't have to pay for it"

Safety truly is an attitude. It is attitude that determines whether or not safety is important. We cannot bypass this component, and, in fact, need to start with attitude in order to get the most out of a safety effort.

What does an "Attitude-Based" process look like. It recognizes that attitudes will either hinder or promote the process, but rarely are they neutral. It utilizes the same types of activities that have been used in the past, but implements them in a different way. Ingredients of a successful injury prevention process include:

a.) Demonstration of a management **Commitment** - Supervisors and employees observe visual, verbal and financial support from management that is unwavering.

b.) Demonstration of **Longevity** - A 1 year, 2 year and 3 year plan is developed. The process is maintained on a daily basis through the development of task forces, presentation of "tool box talks" and informal discussion along with more commonly used tools such as videos and posters . The pace of the process is viewed as less critical than the direction. There is a very recognizable beginning, and no recognizable end.

c.) Demonstration of **Consistency** - It is essential that the employees see that injury prevention is important even when the company is busy. Items are put into place to insure that awareness is high during times when the risk of injury may be greatest. The employees must see that safety is not an addendum to productivity, it is a way of doing business.

d.) Demonstration of **Accountability** - Responsibilities for the process are shared equally between management, supervisors and employees.

e.) Demonstration of **Flexibility** - The ability to evaluate the process on an ongoing basis must be built into the system. A process must have the ability to grow and change as the environment and needs of the participants change.

Title

CHILDCARE TECHNIQUES FOR THE SPINAL CORD INJURED PERSON

Presenters

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Key Words

Spinal Cord Injury
Daily Living Skills
Parenting

Abstract

The practice of occupational therapy focuses on helping people achieve and maintain maximal independence in activities of daily living. As the profession has evolved through the years, it has maintained an emphasis on helping clients successfully make the transition from the hospital back into the community; from a passive patient role to an active role interacting with their environment.

Three major goals of occupational therapy intervention include: 1)reducing deficits in occupational performance, 2)eliminating barriers to occupational performance, and 3)establishing competency in occupational performance. Occupational performance activities are life tasks (self-care, work, play/leisure) that individuals must perform to meet their own needs and to be contributing members of society.

When working with clients, occupational therapists should address normal occupational functions and performance throughout the human life span. A normal occupational function of young adults is parenting. The majority of newly injured spinal cord clients are young adults, therefore parenting and childcare must be addressed.

As society in the 1990's copes with crime, substance abuse, domestic violence, and poverty, we see an increase in single parent families. Unfortunately in many families, parenting and childcare skills are substandard. Parenting and childcare can be difficult for anyone; having a disability can make it a real challenge. Adding in the other factors mentioned, can make it seem like an insurmountable task.

Today rehabilitation professionals and society try to give the message that it's okay to have a disability. Sporting events such as Paralympics, wheelchair basketball, and quad rugby are gaining prominence. Physically challenged people appear in television shows and movies, in advertisements and commercials. They are shown to be friends, employees, consumers, but rarely parents. While parenting is considered a traditional role for most people, it is not considered a traditional role for the disabled person. New technology in fertility and electroejaculation will allow many more individuals with spinal cord injuries to become parents.

As occupational therapists, we can help change this perception that people with disabilities cannot be/are not parents. We propose to advocate the inclusion of parenting/childcare skills as an important part of the rehabilitation of the spinal cord injured parent (or family member). Childcare activities include dressing, bathing, diapering, feeding, lifting and transporting the child.

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Title

A Comparison of Computer Access Devices

Presenters

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Key Words

Computer access, spinal cord injury

Abstract

Although numerous computer access devices exist, occupational therapists are still faced with the challenge of matching the client to the optimal access solution [1]. Access device comparison studies can aid therapists in this process. This study expanded upon prior studies [2] through the evaluation of a combination of low and high technology access devices. Subjects were asked to compare three, Macintosh-based computer access devices: a low technology, conventional mouthstick; a high technology, Prentke Romich Company (PRC) ultrasonic HeadMaster; and a New Abilities Tongue Touch Keypad System, a high technology, prototype device new to the commercial market.

The purpose of the study was to explore subjective and objective ratings of device performance. A single-subject study was implemented using a sample of three subjects with high-level quadriplegia and no prior Macintosh experience. Subjects used the mouthstick for a week-long baseline period, followed by a treatment period in which each subject used each of the three access devices for one month. Data were recorded twice weekly, and graphically tabulated and

analyzed across four areas of comparison: speed/accuracy of text entry, speed/accuracy of cursor manipulations, endurance, and subjective preference ratings of device features. The different access devices were found to have unique strengths and weaknesses. The mouthstick excelled in text entry. The HeadMaster was favored for cursor manipulation. The New Abilities system was preferred for its integration of computer and environmental control.

These results point to the need for extended evaluation of access devices when determining optimal access solutions, and a preference toward integrated access solutions which combine low and high technology.

By replicating the evaluation procedure from this study, occupational therapists can make informed computer access device recommendations to consumers with disabilities. This in turn could provide the basis for the consumer's re-entry into productive employment in our society's diverse work force.

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Title

Survey of Assistive Technology Experiences for Persons With Quadriplegia

Presenters

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Key Words

Technology
Spinal Cord Injury

Abstract

Sustaining a spinal cord injury results in significant impairment in all areas of life. Specifically, dependency in the areas of activities of daily living, work/school and leisure results in the loss of control over the major functions of life. One approach the occupational therapist may use to address these areas of dependency is through the provision of assistive technology. The purpose of this study was to determine the knowledge spinal cord-injured individual residing in Kentuckiana regarding assistive technology.

A mail survey of 84 persons with quadriplegia was completed to determine the types of assistive technology the individuals had been exposed to, whether evaluation had been completed to determine device selection, was training being provided in the use of obtained devices and who introduced these devices to the individual.

The results indicated that the respondents expressed uncertainty/agreement when asked if they had received proper evaluation and disagreement/uncertainty when asked if they felt they had received adequate assistive technology services. The respondents were in agreement that they had been properly trained to utilize equipment they owned.

Title

Difference in AMPS Profile Between Persons with RCVA and LCVA

Presenters

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Key Words Stroke, Impairment, Disability

Abstract

Persons who have survived a stroke constitute the largest diagnostic group requiring rehabilitation services today. Yet statistics have shown that 30% to 60% remain dependent in some ADL skills (Dombovy, Basford, Whisnant, and Bergstralh, 1987). Perhaps more effective rehabilitation could occur if clinicians were better able to document subtle differences among stroke patients, (eg, identification of specific differences between those with right cerebrovascular accident (RCVA) and left cerebrovascular accident (LCVA).

Traditional stroke research has focused on impairment (brain pathology) and the behaviors that can be recognized as secondary to the anatomical loss. Researchers have then speculated regarding how impairments and resulting behaviors might impact on the person's overall ability or disability in activities of daily living (ADLS) and instrumental activities of daily living (IADLS). Consequently, there is limited information with regard to how impairments translate into differences in disability (Bernspång & Fisher, 1995).

The purpose of this study is to investigate (a) are persons with RCVA and LCVA the same or different in overall functional ability, and (b) do hemisphere specific impairments (loss of physiological and or anatomical structure) impact on functional ability in different ways regardless of the level of disability?

The Assessment of Motor and Process Skills (AMPS) is the evaluation tool used in this study. The AMPS has been designed to measure how impairments are manifested in the context of ADL performance. Bernspång and Fisher, (1995) is the only study at this time to investigate the validity of the AMPS when applied to persons with stroke and was based on a small sample.

The current study is being conducted to further obtain specific information regarding the interaction between impairment and disability for persons with RCVA and LCVA. We will test the following hypotheses: (a) persons with RCVA will not differ significantly in overall motor and process IADL ability, (b) persons with RCVA and LCVA will differ significantly in motor and process items that impact on IADL ability.

The subjects for this study will be approximately 360 persons with RCVA and 360 persons with LCVA. They will be taken from an existing AMPS database and will be matched for age, gender, and number of tasks performed. These subjects have been tested by one of 330 occupational therapists trained and calibrated to administer the AMPS.

Rasch analysis will be used to determine the relative item difficulty calibrations of motor and process skills between persons with RCVA and LCVA. To determine overall differences in mean AMPS IADL process ability between those with RCVA and LCVA, a *t* test will

References

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Title Back To The Basics of Biomechanics

Presenters

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Key Words

Biomechanics
bioKinematics
bioKinetics
Center of Gravity
Forces - Torque
Lever systems

Abstract

BACK TO THE BASICS OF BIOMECHANICS

Knowledge of biomechanical principles is increasingly becoming an essential component in the treatment of physical disabilities and work-related conditions (Faulkenburg and Roberts, 1992;Jacobs, 1992). Firmly based in the biomechanical frame of reference (Pedretti and Zoltan, 1990) biokinematics and biokinetics are the application of physics principles to human motion and the forces producing motion (Norkin, 1992). In physical management, biomechanics can be applied to the analysis of muscle forces, movement, exercise and positioning; in industrial settings, use of biomechanical principles adds specificity to ergonomic analysis and recommendations for tool use, lift technique, posture and workstation analysis (Rice, 1992; Smith, 1989; Chaffin and Anderson, 1984). Wheras most occupational therapists studied physics in their undergraduate education, therapists in industrial and rehabilitation settings rarely take the opportunity to apply these principles to specific treatment strategies. Introduction of these basic concepts back into the clinic can provide more focussed and effective treatment delivery.

This workshop will discuss the relevance of biokinematics and biokinetics to specific areas of the occupational therapy profession. It will then present the following four concepts from physics: center of gravity, linear forces, torque (rotary motion) and lever systems. Participants will then apply these concepts to specific clinic situations and to work-site analysis. Participants will have the opportunity to relate these concepts to their own practice. The concepts presented and specific examples can be used as models for specific problem-solving and inservice training in the biomechanical framework.

Objectives of the workshop include the following:

1. Participants will appreciate the relevance of biomechanical theory to specific areas of the occupational therapy profession.

2. Participants will understand the 4 physics concepts presented: center of gravity, torque, equilibrium (lever systems) and linear forces.

3. Participants will apply each physics concept to one clinical application in the area of physical management and industrial rehabilitation.

4. Participants will generate examples of biomechanical principles from their own practices and present examples to the group.

5. Participants will be provided with materials to present these concepts to their prospective facilities as inservice training in the biomechanical frame of reference.

Methods used during this workshop will include lecture, practical demonstration, problem-solving, small groups discussion, and short presentation to other workshop attendees.

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Title

HIGH-RISK OBSTETRICAL CARE:
VALUE IN THE HOME SETTING

Presenters

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Key Words

home health occupational therapy, pregnancy

Abstract

Prevention of preterm births and low birth weight infants often requires prolonged bedrest and hospitalization during pregnancy. This method of caring for at-risk pregnant women, although usually effective, creates significant emotional stress on the childbearing family unit and is a costly method of providing prenatal care. With these issues in mind, a home care program that utilizes an interdisciplinary team approach was developed for high-risk pregnant women on bedrest.

The program, developed to complement care delivered in both the hospital and medical offices of a Health Maintenance Organization (HMO), is provided as a benefit to subscribers. The goals of the program are:

1. To provide an alternative method of delivering comprehensive, family-centered obstetrical care that supports the woman and her family in the home, facilitating the maintenance of bedrest and prolonging pregnancy.

2. To reduce the high cost of hospitalization by decreasing hospital stays, as well as preventing hospitalization and re-admission to the hospital.
3. To reduce the high cost of neonatal intensive care hospital days resulting from premature births.
4. To prevent fetal growth and development problems which can lead to later physical and learning disabilities, costing our nation increased medical and educational dollars.

Candidates for this program are primarily pregnant women whose activity has been restricted. However, other candidates could include disabled pregnant women who need an evaluation of their ability to manage their pregnant condition in their home environment.

The care is provided by an interdisciplinary team consisting of perinatal nurse, occupational therapist and social worker.

Occupational therapists address the physical, psychosocial and cultural consequences caused by the occupational role loss experienced by women on bedrest. These include loss of musculoskeletal strength, slow return to normal functional activities after delivery, depression, anxiety, loss of daily routine, boredom and family disruption. The occupational therapist uses purposeful, goal-directed activity to:

1. Facilitate bedrest by:
   * adapting activities of daily living and the environment
   * instructing in avocational activities
   * maintaining occupational roles of parent, homemaker, worker, volunteer, student
   * instructing in stress- and time - management techniques
   * instructing in maternal role preparation
2. Minimize the deconditioning effects of bedrest
3. Maintain mobility and ADL skills for the physically disabled pregnant woman.

In 1993, the program savings were estimated at $773,400 with a cost of $85,380. These savings do not include estimated neonatal intensive care costs that are being avoided. We have on the average, extended our patients' pregnancies 5.9 weeks. Our mean gestational age at delivery has been 36.5 weeks (37 weeks considered term). Only 12% of our patients in 1993 delivered at less than 34 weeks gestational age.

Most rewarding of all has been the individualized, family-centered care our team has provided our patients. We have improved our patients' ability to maintain and cope with bedrest, providing them with the support and knowledge required to manage their pregnancy complication at home. Our innovative program allows the pregnant woman to stay at home with her family, aids in prolonging her pregnancy and saves our nation's health care dollars.

Title

GOING HOME: HELPING PATIENTS PREPARE FOR DISCHARGE

Presenters

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Key Words

Local world, culture, ethnic groups, discharge planning, goal attainmentscaling Community Adaptive Patterns Assessment

Abstract

This workshop will offer clinicians an opportunity to learn how to use the concept of local worlds and to include ethnic and racial differences when planning for discharge of their patients. Through interaction with colleagues in small groups clinicians will develop strategies to apply cultural information to their own work setting.

Workshop Title: GOING HOME: HELPING PATIENTS PREPARE FOR DISCHARGE

The purpose of this workshop is to address the importance of occupational therapists helping to prepare patients/clients of different cultural backgrounds for discharge from hospital to home. The use of the concept of local worlds will be examined as a way of looking at cultural differences in discharge planning. The presentation will consider several issues related to discharge including attaining personal goals and using family support systems, the relevance of patients' past experiences and competencies in planning for discharge, and how patients continue to work on clinical goals once they are home. Three OT faculty from Texas Woman's University (TWU) in Houston, TX, will share in the presentation of the workshop and discuss their research studies. The first of these is a chart-review study of discharge planning received by elderly Black, Hispanic and White stroke patients from three different ethnic backgrounds. The only significant difference found among the ethnic groups was that the Black elders received fewer home evaluations than the others. A second study along this line of research investigated the use of family and community support systems by Hispanic stroke patients and their families following hospital discharge to their local worlds. Findings indicate that the kinship network was essential to the elders' wellbeing, while community care services were sought less often. Several studies used the Community Adaptive Patterns Assessment developed at TWU to document changes over time in the daily occupations of persons with strokes, multiple sclerosis, and arthritis. Findings indicate that this tool is a useful way to synthesize information on how persons with disabilities function within the physical and social environments of their local worlds. The last study is related to the carry-over goals of hospitalized white working-class psychiatric patients to their local worlds, and the implications for practicing occupational therapists. Goal attainment scaling was used to measure clinical progress in achieving goals while in treatment. Follow-up one month following discharge showed that the most patients report that they continue to work on their goals, though they often have difficulty articulating specific activities they are doing. However, less than half report satisfactory involvement in community activities.

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Title

Interdisciplinary Team Approach in ICU

Presenters

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Key Words

Stroke
Interdisciplinary team
Clinical pathways

Abstract

As health care changes to a more managed care system with emphasis on decreasing length of stay and alternative means to provide rehabilitation services to patients an early team approach to patient treatment increases clinical effectiveness and cost effectiveness. Forsyth Memorial Hospital (FMH) and the associated rehabilitation center, John C. Whitaker Regional Rehabilitation Center, envisioned a greater continuum of care with early intervention for the patient diagnoses of stroke in 1991. Chart audits revealed many of the patients transferred from the acute care facility, FMH, received only physical therapy prior to the transfer and began the other therapies including occupational, speech and psychology only after admission to the rehabilitation center. The hypothesis was if all therapies that were beneficial to the patient could start earlier the patient outcomes would improve and length of stay would decrease thus began the acute stroke team.

The stroke team is comprised of Occupational, Physical, and Speech therapies, Psychology, Social Work and Nursing. Patients admitted to the neurology floor receive a stroke team consult in the first 24-48 hours post stroke. Each discipline screens the patient and makes recommendations on an interdisciplinary assessment. Patients are discussed in a team meeting weekly to assess progress and discharge planning. Notes generated from this conference are

posted in the chart to communicate with the physician on the patient progress and recommendations. The feedback we have received from the physicians is positive; they feel the team approach assists with early discharge planning decreasing length of stay and improves the ability to provide early family education. Several physicians have used the stroke team for a team approach to patients with other diagnosis than stroke; Dr. Christian Dean, neurologist, said "I know I abuse the system but you help me find the best discharge disposition promptly for my patients so I use it for other patient populations."

In February of 1994 the hospital administration heard of the stroke team and approached the team to assist in the writing of a clinical pathway for the left hemisphere stroke excluding hemorraghic and brainstem strokes. After many hours of work our pathway was functional for trial in August 1994. A small study of five patients was done; revisions were made and the trial continued for several more patients. The pathway has made some radical changes from it's original form and has become a stroke pathway regardless of the hemisphere. We accomplished this by aiming for the pathway to standardize the treatment approach but allow for individual, daily outcomes which are written onto the pathway. It has been exciting to be part of the pathway team and participate in the development of the pathway. The interdisciplinary Team approach and the development of the clinical pathway has increased our efficiency, quality and cost effectiveness in treating the patient who has suffered a stroke.

Dean, C (1994, Dec.) Stroke Team. Presentation at Clinical pathway meeting Forsyth Memorial hospital, Winston Salem, NC.

Duncan, P. (1993, October) Effectiveness of Stroke Rehabilitation. Presentation at National Stroke Symposium,

Title

Practice and Occupational Performance

Presenters

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Key Words

memory---motor learning---motor control

Abstract

Motor learning research has a long history of investigations delineating the processes underlying the acquisition, retention and transfer of skills (Magill & Hall, 1990). This research has begun to impact the field of occupational therapy. In occupational therapy, motor learning concepts are increasingly being used to justify and explain specific rehabilitation approaches such as those proposed by Abreu, Hinojosa and Toglia (Abreu & Hinojosa,1992; Toglia,1992). Practice variables are suggested as critical factors affecting the learning and re-learning of movements and skills (Jarus 1994).

In spite of the significance of the organization of practice, occupational therapy research has not focused on the effects of practice context on learning or relearning of movements. Extensive literature in the motor learning area, however, suggests that variability in the movement parameters, the amount of practice and the practice schedule differentially affect the learning and memory for the generalized motor program underlying a movement.

The objective of this research was to determine the effects of amount of practice, variation in the movement parameters and practice schedule on the learning and generalization of the motor program in a goal directed task. In this experiment 108 young adults learned a computerized timing task with the amount of practice, movement organization and practice order of the movements varied across conditions. Subjects were required to tap a board in a prescribed sequence. The timing of the movement was determined by the set criterion movement times that subjects were given for each of the three movement segments on each trial. Eighteen subjects were randomly assigned to one of six treatment groups. Three levels of organization of practice were crossed with two levels of amount of practice. Task order was counterbalanced across subjects. The experiment consisted of an acquisition phase, a retention phase, and two transfer conditions. Movement time error was analyzed for program learning using a three factor analysis of variance with repeated measures on the last factor.

The results of this experiment suggest that amount of practice is an inconsequential variable in practice relative to the effect of the organization of the practice session on learning and transfer of movements in adults. These findings are discussed relative to causal explanations of learning and memory for normal movement programs. Implication of these findings for occupational performance and treatment and future studies with other functional tasks and with atypical populations are presented.

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Title Single Design Applications of Motor Learning Principles

Presenters

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Key Words

Motor Control
Movement Analysis
Single Subject Design

Abstract

Many of the treatment techniques utilized with neurologically - involved patients in occupational therapy have not been studied in a systematic manner to determine their effectiveness in fostering recovery of an individual's motor abilities. In a health care environment that is focusing increasingly on outcomes, the ability to demonstrate carryover of a task practiced in therapy to an individual's daily life following therapeutic intervention has taken on an even greater importance. Recently, the principles of motor learning have been explored as a means of addressing these issues (Jarus, 1994; Poole, 1991; Saberi, 1991). Motor learning theory should be of particular interest to occupational therapists because of its emphasis on the role of meaningful, goal-directed activity in promoting motor skill acquisition. Although these methods may hold promise for developing more consistent approaches to re-training motor skills, studies of these principles up to this point have primarily involved normal subjects (Schmidt, 1988; Winstein 1987). The role of feedback and practice as well as the interplay of the individual, task and environment in learning motor skills are among the concepts that need to be examined more closely if the efficacy of treatment is to be more clearly established.

Given the diversity of deficits and abilities in neurologically-involved patients, single subject research design may offer a viable way to study the potential for the application of motor learning theory with this population (Ottenbacher, 1986).

The purpose of this presentation is to discuss principles of motor learning theory and its application in functional activities with neurologically-involved individuals. Examples of single subject research design will be used to illustrate methods of examining the efficacy of treatment techniques incorporating this model.

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Title

Changing Ideas About Motor Control

Presenters

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Key Words

Motor control, treatment theory, physical disabilities, theoretical models

Abstract

Theories of motor control constitute a significant theoretical framework for the practice of occupational therapy in physical dysfunction, for adult and pediatric practice. The treatment plans that therapists develop for patients with neurological and orthopedic deficits should be guided by theories of rehabilitation that are based on underlying models of motor control. Therefore, changes in motor control theories should have considerable impact on the practice models and techniques that therapists use for working with clients who have physical dysfunction problems.

The original motor control models were simple linear, reflex-based models which described the motor system as sets of reflexes connected in series. Later, the reflex models evolved into more complex hierarchical models in which a single higher control center issued commands to lower level centers that carried out the commands in a relatively inflexible manner. Current practice is largely based on theories that were developed using the reflex and hierarchical models, such as Neurodevelopmental Therapy and Sensory Integration. Unfortunately, the reflex and hierarchical models of motor control suggest rigid systems that are unable to adapt well or cope with complexity. These ideas cannot be realistic since normal motor systems are characterized by their remarkable abilities in adapting to new situations, fine tuning motor programs to fit unique environmental demands or for skill refinement, and time-sharing ability for multiple task demands. Therefore, in the past twenty years reflex and hierarchical theories have been giving way to distributed control theories. In a distributed control model the system has several, movable center of control, which change as needed, depending on the tasks demands at the time. Commands are still issued at higher levels and carried out at lower levels, but the levels are more flexible and more than one center can be in control.. Also, unlike the hierarchical models, information can flow easily in both directions between higher and lower level centers since the roles of each center are less rigidly defined.

These changes in theoretical constructs require changing the practice models. Therapists should be aware of changes in motor control theory because the changes lead to new frames of reference, new models of practice, and thus new ideas about effective treatment techniques. As the new theories develop, of course, they should be tested empirically to determine if the theories are correct, i.e. to determine if they work. By becoming familiar with the changes in theoretical models and by participating in the development of better models clinicians can improve the treatments they offer their patients and affect the growth of their profession.

Title

Community Agencies Distribute Recycled Assistive Equipment

Presenters

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Key Words

activities of daily living
self-help devices
self-care

Abstract

The Pre-Owned Equipment Project is the result of collaboration of 22 agencies in Western Pennsylvania to recycle medical supply and adaptive equipment to individuals who qualify diagnostically, geographically and financially. The project was spearheaded by the Western Pennsylvania Arthritis Foundation and for the past two years individuals representing the multi-agencies have met to organize and implement the plan.

All agencies in Southwest Pennsylvania were invited to participate and examples of those who agreed include the Amyotrophic Lateral Sclerosis Association, Make-A-Wish Foundation, National Stroke Association, Myasthenia Gravis Association and Three Rivers Center for Independent Living. Also medical supply company's owners were included so as not to infringe on their business, but rather to encourage their cooperation and to use their expertise in the project. Attorneys offered valuable legal advice relative to the task at hand.

Each agency provided a letter of intent to indicate their agreement to participate and assure that their individual charters, bylaws or other resolutions, agreements and governance measures would permit this type of collaboration in the project. The concern here is that each participating agency has investigated whether it has the capacity and the authority to join with other agencies in founding and operating an exchange of pre-owned equipment.

Sub-committees were formed to develop a) a method for determining need; b) criteria for clients to obtain equipment based on financial status and third party reimbursement; c) a mechanism for establishing a data base; and d) a plan for the physical operation of the project and various operating models. The results of the sub-committees' deliberations are presented.

A time line for activities was determined with expectation that the project would be implemented within 10 months which was actualized. Those determinations about client criteria and policies, which changed over time, are discussed.

This paper presents relevant information about the processes involved in establishing the project together with specific details about its operation. The legal issues, such as waivers and liability, are presented. Forms utilized for gathering data, such as agency invitations to participate, letters of intent, needs assessment, monthly reports of equipment received and distributed are provided.

The project is presently using an existing agency as a conduit for accepting, inspecting, repairing, if necessary, and distributing the equipment to individuals who request it. Methods for assessing clients' needs for specified equipment and instruction in the use of specialized equipment is offered.

The need for development of an executive committee, made up of a limited number of agencies, and given the authority to make decisionsin a timely fashion is demonstrated. Future directions and funding proposals is discussed.

Title

Comprehensive Rehabilitation of Visual Field Deficit Following CVA

Presenters

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Key Words

homonymous hemianopsia, visual field deficit

Abstract

Visual field integrity represents one of the foundation visual skills necessary for the development and integration of higher level visual perceptual function (Warren, 1993). Visual field deficit (VFD) is the most common visual deficit occurring following CVA. Individuals with VFD typically exhibit four behavioral changes following onset: 1) a narrowed scanning pattern restricted to midline and the sound side 2) a slow scanning pattern towards the affected side 3) a tendency to miss or misidentify visual detail on the involved side and 4) reduced visual monitoring of the hand in activities. Adoption of these behaviors results in deficient performance in many areas of daily living including orientation and mobility within the environment, reading, writing, completion of eye/hand activities, and driving. The behaviors occur in part because of the phenomenon of perceptual completion wherein the brain perceptually fills in the missing portion of the visual field leaving the person with the impression that he/she is seeing a complete visual field. (Levine, 1990)

The presence of VFD is often overlooked during evaluation or is misdiagnosed as visual neglect or hemi-inattention. Careful observation of patient performance on evaluations designed to identify inattention can help differentiate between the two conditions. Patients with VFD, but without neglect, demonstrate an organized and systematic scanning pattern on cancellation tests although the pattern may be abbreviated on the non-seeing side. They also re-scan the completed test to check for errors and ensure accuracy. Neither of these behaviors is typically observed in the patient with visual inattention. Quantification of the visual field deficit is completed using perimetry. Automated perimetry provides the most accurate description of the deficit; confrontation testing provides only a gross measure of the deficit and often overlooks subtle deficits (Trobe, Acosta, Krischer & Trick, 1981).

Treatment of VFD concentrates on replacing the ineffective behaviors adopted following onset with strategies to enable the patient to compensate for the vision loss. Use of an organized scanning strategy utilizing a wider and faster head turn towards the blind side is emphasized to improve orientation and mobility skills. Activities which require the patient to initiate precise eye movements to accurately identify visual detail and visually monitor hand movement are used to improve reading performance and eye/hand coordination. Resumption of driving can be a realistic goal for individuals who are able to consistently employ compensatory strategies, and who live in states where visual field restriction does not prevent licensing. Success in treatment ultimately depends on the patient's understanding of how the visual deficit has limited functional performance and his or her willingness to employ compensatory strategies.

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Title

Worker Role Interview for Diverse Injured Workers

Presenters

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Key Words

work disability, psychosocial and environmental factors, worker role interview

Abstract

Work disability has a great socioeconomic impact on the society. Recent findings suggest that psychosocial and environmental factors play a significant role in chronic work disability (Feuerstein, 1991; Waddell, 1987). In turn, the Worker Role Interview (WRI) was designed to assess the impact of psychosocial and environmental aspects upon client's return to work following industrial injury. While the construct validity of the WRI has been previously demonstrated for clients with low-back pain (Gern, 1993), this study investigates the generalizability of those findings to clients with different types of injuries. Furthermore, the differences in scoring on the WRI across different diagnostic groups were examined.

Fifty-five clients from four work hardening programs were interviewed and rated by four occupational therapists using

the WRI. Rasch logistic model (Linacre & Wright, 1993) was used for data analysis.
The findings revealed that the WRI is valid across diagnosis, and the 17 WRI items comprise a unidimensional construct which pertains to client's psychological wellness and social-environmental supports for returning to work. Furthermore, the findings indicated that the WRI is a useful instrument in terms of reliably differentiating clients with different levels of ability for returning to work. In regards to comparison of person abilities between groups, the results showed that no significant difference in WRI scores between clients with back injuries and clients with extremity injuries. Based on the results from this study and previous WRI-related studies, we proposed a model for further revision of the WRI and its implications for occupational therapy practice.

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Title

The Development of an Environmental Scale for Industrial Rehabilitation

Presenters

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Key Words

Industrial Rehabilitation, Data Base, Outcomes

Abstract

ABSTRACT

This study represents the continuation of an ongoing project to create a data base for occupational rehabilitation programs. The Occupational Rehabilitation Data Base Instrument (ORDB) is being developed in response to the increasing demand for standardized assessments to evaluate program effectiveness in work-related practice (Velozo & Santopoalo, 1993). It has been theorized that physical and environmental factors influence return to work following injury (Feurerstein, 1991). However, while most assessments of the injured worker focus on physical factors, few integrate environmental factors. The ORDB addresses this deficit by assessing both the worker's functional capacity and perceptions of environmental factors. Preliminary Rasch analysis of 230 work injured clients from 30 rehabilitation sites across the country show that the ORDB instrument has good person separation reliability (.92) and is fairly well matched for the clients under study. Further analysis will determine whether the instrument can be divided into two separate scales, one representing work capacity and another representing perceptions of the environment.

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Title

Cultural Validity of Assessment Tools

Presenters

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Key Words

Parent-child interactions, cultural differences

Abstract

In order for assessment to be effective they need to be sensitive to cultural differences. The Nursing Child Assessment Satellite Training (NCAST) scale is an assessment tool used to evaluate quality of parent-child interaction. Currently the NCAST database includes norms for Caucasian, African American and Hispanic populations but does not have norms for the Asian population. The purpose of this study was to assess the validity of the Nursing Child Assessment Teaching Scale (NCATS), the teaching component of the NCAST scale, when applied to Asians specifically, Sri Lankans. A descriptive study was chosen to identify similarities and differences between the scores obtained by Sri Lankan mother-child dyads and the established U.S. Caucasian norms for the NCATS. The research was conducted in Sri Lanka. The 15 child subjects were in the range of 5 months to 3 years. The parent-child interactions were videotaped and then coded. The Sri Lanka mean scores on all of the NCATS subscales were lower than the norm means,

with Z test scores of $p < .001$ on the cognitive and social emotional growth fostering subscales. The findings of this study suggest that U.S. Caucasian norms for the NCATS may not hold true for Sri Lankan mother-child dyads.

Title Cognitive ergonomics: Optimizing performance for cognitively disabled workers

Presenters

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Key Words

Cognitive rehabilitation
Industrial rehabilitation
Brain injury

Abstract

Return to work is one of the ultimate goals of rehabilitation as well as one of the most troubling long term problems for brain injury survivors (Ezrachi, Ben-Yishay, Kay, Diller, & Rattok, 1991). Because cognitive (as opposed to physical) deficits often pose significant challenges to vocational reentry (Wehman, Kreutzer, Sale, West, Morton, Diambra, 1989), cognitive ergonomics represent occupational therapy's important contribution to cognitive rehabilitation programming.

The term "cognitive ergonomics" reflects a merging of concepts from industrial and cognitive rehabilitation. It refers to the therapeutic manipulation of cognitive strategies, task requirements, and environmental variables (Dougherty & Radomski, 1993) in a treatment process comprised of cognitive compensatory strategy training (Sohlberg & Mateer, 1989), job analysis, and context-specific strategy adaptation.

Compensatory strategy training involves teaching persons with cognitive deficits to circumvent problems with memory,

attention, and organization through use of day planners, alarms, checklists, and re-instated or novel routines (Davis & Radomski, 1989). The individual's job is studied using a work-methods analysis (Putz-Anderson, 1990) which incorporates a cataloging of job components and determining areas of "risk". For example, factors are analyzed specific to the worker, work tasks, and work environment (Isernhagen, 1988). The occupational therapist then assists the client in adapting the previously-learned strategies to match the specific requirements of his or her job.

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Title

Clinical Reasoning in the Era of AIDS

Presenters

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Key Words

AIDS, Clinical Reasoning, Staff Development

Abstract

Clinical reasoning can assist staff and students to: a) learn to set treatment priorities in light of placement options and projected status and; b) effectively deliver services to patients with complex medical issues secondary to AIDS. This roundtable discusses a model which has been used to both enhance staff comfort levels for treating AIDS patients, and teach priority setting and clinical reasoning principles.

The model engages students and staff in three sequential seminars. During the first seminar, a master clinician highlights her clinical reasoning process through the presentation of a complex case story. Occupational therapy assessment and treatment strategies for evaluating functional issues in clients whose treatment is complicated by AIDS-related symptomatology, and cultural and continuum of care issues are presented. Sample case materials are discussed during the roundtable.

Treatment contexts presented in the seminar include a community-based AIDS facility and an inner city rehabilitation hospital. Throughout the first session, didactic information regarding AIDS-related symptomology is used to augment clinical materials. During the second and third group meetings, each participant presents an abbreviated (15-20 minute) case story. Using group discussion, the thinking behind treatment decisions is examined. Activity selections which could be used in two diverse treatment contexts are compared and contrasted.

A series of guided questions related to procedural, interactive, and conditional reasoning tracks (Mattingly and Fleming) and the pragmatic/contextural perspective (Schell and Cervero) structure all case discussions. Therapists are encouraged to view their actions in the context of the values they hold as well as the values of their clients and organizations. Altered treatment hypotheses due to increased sensitivity to the patient's perspective of their health status and life situation are highlighted during the discussion.

***Seminar Outline*:**

I. Initial Identification

- A. Pathophysiological findings (Procedural)
- B. Social history (Interactive)
- C. Initial impression (Conditional)

II. Refined Identity

- A. Physical and functional assessment findings (Procedural)
- B. Occupational history and clinical observations (Interactive)
- C. Adjusted picture and residual handicaps (Conditional)
- D. Personal, organizational and environmental resources, values, constraints and expectations (Pragmatic)

III. Treatment Decisions

- A. Procedural
- B. Interactive
- C. Conditional
- D. Pragmatic

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Title

Overcoming Size Discrimination in Health Care

Presenters

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Key Words

Obesity
Discrimination
Attitude of Occupational Therapists

Abstract

Please note: the word "fat" is used throughout this abstract as a neutral descriptive term such as tall, short, or thin. The author realizes that many people are uncomfortable with this word but views this discomfort as a reflection of the negative attitudes this workshop addresses. It is important to note that most people involved in size acceptance activities prefer the use of the word fat over such terms as overweight or obese.

Strong negative feelings about fat people exist in our society.[1] [2] Any doubts about that are dispelled by a recent poll in which half of the 18 to 25 year old women surveyed said that they would rather be dead than fat.[3] Studies show that because of these negative feelings fat people face discrimination in employment, education, social interactions and health care.[4] [5] [6]

This workshop focuses on size discrimination in health care and the ways that we, as health care providers, can overcome it in order to provide quality care to fat people.

The first step is recognizing the problem. Size discrimination is defined and its relationship to substandard treatment is presented through case narratives.

Current scientific data, which disputes many common beliefs about fat people, is presented.[7] [8] An understanding of this information enables therapists to separate fact from long held cultural myths which fuel discrimination.

The issue of how personal fears about fat and body size effect interactions with fat clients is discussed.[9] Recommendations for ways to address this issue on a personal level are offered as well as strategies for addressing size discrimination by others in the work place. Ways to achieve a "fat friendly" treatment area are outlined and sources for appropriately sized products and size acceptance publications are provided.

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Title

The role of occupational therapists in team decision making.

Presenters

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Key Words

patient care team decision making patient discharge

Abstract

Few studies have examined how rehabilitation teams determine appropriate housing for clients ready for discharge, nor the role of occupational therapists in this process (Hoyer & Clancy, 1988). While team decision making enables exploration of a wide range of opinions, it is also prone to phenomena such as group think and decision polarization (Janis, 1982; Myers, 1982). This paper presents research examining whether decision polarization occured in teams when housing recommendations were formulated for stroke clients, and the role of occupational therapists in the decision process.

The research was conducted with thirteen multidisciplinary teams at seven rehabilitation facilities. Using a Social Judgment Theory perspective, individual clinicians and teams were asked to judge the most suitable housing for fifty hypothetical patient case studies (Stewart, 1988). A multi-method approach was adopted in data collection enabling both qualitative and quantitative analyses. The results indicated that decision polarization occurred in all thirteen teams; the more team members disagreed, the more the teams' decisions polarized to more restrictive or independent forms of housing. However, an ANOVA procedure revealed that team decisions shifted to align most closely with the housing recommendations made by occupational therapists and physicians (F (5,68) = 3.511, p < .001). In addition, analyses indicated that occupational therapists, social workers and physicians also spoke most frequently in team meetings (F (5,54) = 11.239, p < .001). These findings suggest that occupational therapists and physicians play an influential role in guiding teams to arrive at housing recommendations for stroke clients. Occupational therapists' knowledge of client ADL skills appeared to be central to the decision process. The paper concludes by suggesting ways occupational therapists can consolidate their role in advising rehabilitation teams on suitable home environments for clients, and promote their expertise in this area.

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Title

Integrating Environmental Factors into Functional Assessment

Presenters

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Key Words

Functional assessment, enviornment, measurement

Abstract

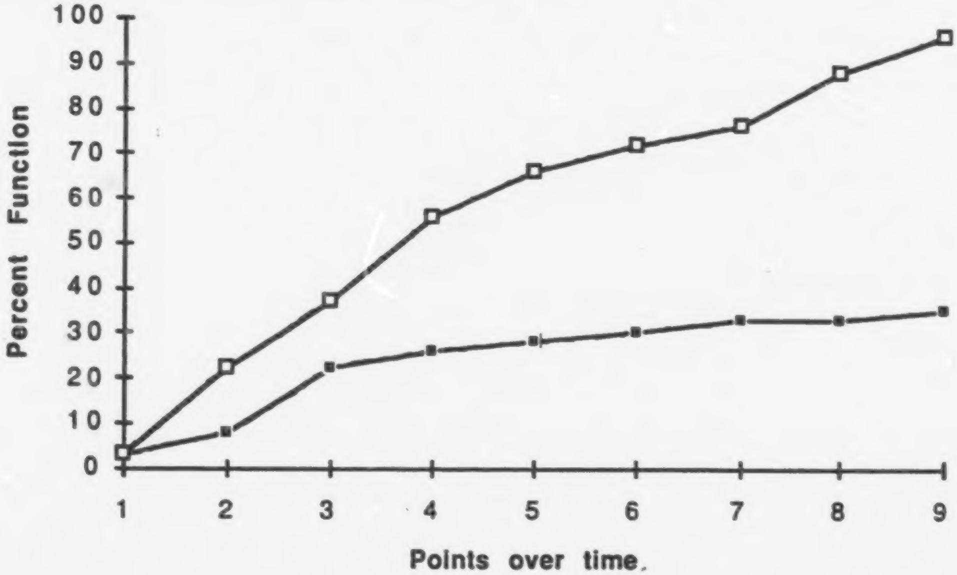
In occupational therapy we believe that individuals can become independent in functional performance with the use of assistive devices or adapted environments. Traditionally, we have documented this progress in narrative format since typical quantitative assessments do not detail the differences between a person's intrinsic function versus that which occurs in an assisted environment. Yet, our professional charge to assess clients' function in environmental context is clear (Fisher & Short-DeGraff, 1993) and a challenge (NICHHD/NIH, 1993). This presentation highlights the value of examining function under varying conditions, how it accommodates individual differences to avoid cultural bias, and how computer assisted assessment makes this process easier.

Learning Objectives: Following this lecture (using overheads and computerized projection) participants will be able to:

1) Define the *Environment-Free* and *Environment-Adjusted* assessment.
2) Explain why traditional assessment approaches cannot accommodate individual differences easily.
3) Highlight how computer assisted assessments such as OT FACT can efficiently document *Environment-Free* and *Environment-Adjusted* functional performance.

The attached graph depicts two lines of functional performance. Mini-case: the bottom line of the graph represents the function of a person with a high spinal cord injury over time when no aids or environmental adaptations are used. (*Environment-Free* function.) The top line in the graph shows how the person functioned when using assistive devices, when his house was adapted for wheelchair access and when his spouse set up a regime to support his meal-time needs. (*Environment-Adjusted* function.)

There are several implications of performing functional assessment with this approach. First, this method describes actual functional performance in natural settings more informatively than traditional one-time assessments. Second, it highlights the relationship of the environment with function. Third, computer assisted assessment facilitates the automation of generating graphical assessment results (Smith, 1993). This assessment approach helps occupational therapy retain a "cutting edge" competency in functional assessment.



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Title: Evaluating Sensory Input Strategies with the Neurologic Patient

Presenters: Laura VanPuymbrouck, OTR/L

Key Words - BRAIN INJURY, LONG-TERM CARE

Abstract

Therapists often struggle with the justification and effectiveness of sensory stimulation with low level neurologically impaired individuals. Sensory stimulation theory stems from studies of sensory deprevation and its effect on cortical functioning. (Suedfeld, 1969, Cohen, 1967) The common method of sensory stimulation is to apply stimuli to varying sensory systems ,with potentially non-purposeful information. (Zasler, Kreutzer, Taylor, 1991) Functional goal achievement is typically not an expectation. (Rader, 1988) There is new support that a regulated input of personally meaningful information may be more effective in arousing the low level patient. This method of stimulation is Sensory Regulation. (R.L. Wood, 1991) Sensory Regulation is based on information processing theories, and has very different procedures and techniques than does classic sensory stimulation. Information processing includes the cortical functions of awareness, selective attention, vigilance, and habituation as prerequesite cortical skills necessary for interactions with the environment. Sensory Regulation programs incorporate these processes into its approach. Another component of Sensory Regulation is use of personally meaningful information. This information. This information is gathered from indepth intake procedures,

(CONT)investigating individual preferences, dislikes, and routines. This approach, concidering personality and cultural diversity is core to any Occupational Therapist's treatment, including the low level neurologic patient. Utilizing personally relevant activities allows for development of a treatment approach that has a more functional basis.

This discussion defines the differences between sensory stimulation and sensory regualtion and how Occupational Therapy can optimize the patient's cortical processing toward goal directed tasks.

At the conclusion of this session participants will be able to: Identify the theories supporting sensory stimulation and sensory regulation, describe unique components of each approach, identify regulation activities for achieving functional goals, and identify Occupational Therapy goals utilizing a sensory regulation approach.

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Title

Ergonomic Redesign With Employee Participation

Presenters

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Key Words

Ergonomics, Participation

Abstract

It is widely believed that the most effective control for musculoskeletal injuries is ergonomic job design. The goal of ergonomics is to improve worker performance and safety by maximizing the fit between workers and the work they do (1). Recent legislative changes brought on by the Americans With Disabilities Act, Occupational Safety and Health Administration, and Workers' Compensation insurance are promoting ergonomic practices and creating a new demand by employers for occupational therapy consultation services in this area (2). The consulting occupational therapist must analyze the interactions between the job, worker, and workplace and make recommendations for changes that minimize potential health hazards.

OSHA recommends the incorporation of ergonomics into the workplace via a comprehensive program, as outlined by the OSHA publication 3123 (3). The program elements include: 1) worksite analysis, 2) hazard prevention and control, 3) medical management, and 4) training and education. These guidelines call for the formation of an ergonomics committee of which the occupational therapist may be a part of. They suggest that all employees be informed of ergonomic hazards and abatement methods at a level consistent with their need and ability to use the information.

An understanding of the dynamics of employee-management participation in worksite redesign can help the consultant in designing a program and an approach that will maximize the potential for successful intervention. Participation research emphasizes the importance of how the type and form of participation in decision-making greatly effects the outcome of an interaction (4). Literature suggests the most effective strategy for employee participation is one that incorporates informal, direct, high-access, and long term aspects (2). The consultant must make a concerted effort to informally involve workers in the identification of ergonomic-related problems and solicit ideas for improvements in work tasks.

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ASSISTIVE TECHNOLOGY LABS

Title

Baby Care Equipment for Parents with Disabilities: Assessment and Intervention

Presenters

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Key Words

-Assistive Equipment
-Physical Disabilities

Abstract

It is estimated that at least 8.1 million families with children have one or both parents with a disability or work limitation (La Plante, Miller and Miller, 1992). Parenting with a disability is more common now as reflected in a modest number of articles in mainstream magazines, professional journals and newsletters (Kirshbaum, 1988; Maddux, 1986 Staff, 1989) and resource books (Enders and Hall, 1990). There is still a scarcity of research concerning the use of baby care assistive devices for parents, and no systematic research concerning intervention approaches, effectiveness or impact of assistive equipment (Post, 1993).

The research sponsored by the National Institute on Disability and Rehabilitation Research (NIDRR), was conducted to analyze the effectiveness and impact of baby care equipment for parents with physical disabilities. An in-depth longititual study, reflecting physical and psychosocial perspectives, was conducted with 15 families. Qualitative and quantitative measures were developed to analyze the impact of the interventions on parents' baby care, using pre and post intervention videotapes. Videottapes were assessed by multiple raters to assure adequate inter-rater reliabiltiy.

With the assistance of engineers the project constructed and analyzed both simple and elborate equipment. Unexpectedly, some of the most effective kinds of equipment were those which provided appropriate surfaces or "props" on which to perform baby care tasks. An additonal finding was that interventions with tasks such as "carry/moving", "transfer", "positonal changes", and "holding" had an equal or greater impact on parents' ability to perform baby care as did intervention with specific baby care tasks such as feeding or bathing.

Preliminary results of the study indicate that many parents showed changes in "ease of task", "work simplication", "physical assistance" and "flow of task" as a result of intervention. From a psychosocial perspective, psychologists noted in many cases parents became less preoccupied with the task and demonstrated increased pleasure in their interaction with their child.

The study indicates that sensitive assessment tolls are essential for analyzing parents' equipment needs and effectiveness. In order to meet the needs of parents with physical disabilities intervention must consider both physical and psychosocial aspects of baby care because assistive equipment can have an enriching impact on the parent-child relationship.

Future research should focus on further refinement of the assessment of physical and psychosocial intervention, using a larger sample of families. In addition, analysis of the cost and psychosocial impact of assistive devices on use of attendant care would be a useful contribution to the field. Related research is being pursued at our NIDDR-funded Research and Training Center on Families of Adults with Disabilities.

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Title

Computer -Based Assessment Tool for Children With Disabilities

Presenters

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Key Words

Assessment, Visual Perception, Computers

Abstract

The purpose of the demonstration is to introduce a set of computer programs designed to assess visual perceptual skills of developmentally impaired children who function on a two-to-five years old level.

Visual perception skills are crucial for interpretation of information from the environment (Williams, 1983; J.J. Gibson, 1966 and E.J. Gibson, 1988). Deficits in visual perceptual skills are a frequent factor impeding functional performance (Bouska, Kauffman, & Marcus, 1990). Occupational therapists evaluate, train, and remediate visual perceptual skills. Accurate assessment is necessary for appropriate intervention.

Computers have become widely recognized as valuable tools in the area of rehabilitation and education for people with disabilities. The unique attributes of computers make them a powerful tool for the assessment of the perceptual and cognitive skills of children. (Loebl, 1982, 1993).

The computer-based assessment tool "Colors & Shapes" will be presented. The programs introduce colors and shapes in three levels of complexity. Once color and shape discrimination are mastered, the therapist can focus on other perceptual skills, such as figure-ground discrimination, object constancy and association. The programs are fun, motivating, age-appropriate, and can track the child's rate of success.

The set of programa were designed and developed by the presenter. It is based on neurological development, information processing, and learning theories. These programs are published by BEST Inc. and have been field tested in Israel and in the United States.

Objective

The objectives of the presentation are to:

1. Demonstrate the software to therapists.
2. Present the use of these programs as an assessment and remediation tool.

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Title

CONTOURED SEATING FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES

Presenters

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Key Words

Wheelchairs and accessories; developmental disabilities; seats, adaptive.

Abstract

Individuals with severe developmental disabilities will benefit from contoured seating by allowing the individual to be more upright for longer periods of time; providing a comfortable seating base; lessening the risk for decubiti; and providing stability. Contoured seating provides increased surface contact over planar seating. By this method, pressure is distributed so no one area has to bear a large amount of weight. We have found contour seating systems to be better suited for those individuals with contractures, asymmetries, obliquities, rotational patterns, severe scoliosis and/or kyphosis. A contoured seat supports the patient's body and may be considered for individuals who are dependent in activities of daily living or for those who need stability in order to be more functional.

We continue to use planar seating systems for individuals with minimal to moderate involvement. Planar seats allow for easier transfers (both assisted and unassisted), to don/doff clothes while seated, and to propel with feet.

We have used contoured seating for clients with gastroesophageal reflux who need to be upright during and after meals. Contoured seating has provided a means to bring clients to a semi-upright position so they can visually interact with their environment. Contoured seating has also benefited individuals with athetosis providing a more stable seating base to support the pelvis, trunk, and lower extremities to facilitate the individual's participation in functional activities.

We do our contoured seating in-house to lower costs. The availability of trained and experienced staff allows for extended assessment and trial period, and changes to the seating system can be made easily and quickly. Individuals with developmental disabilities "grow" into their disability and are in a constant state of change and adaptation. With in-house seating systems, records of these changes help formulate optimal seating options.

A seating system is simulated for the individual several times on different days. Behavior may vary from day to day, depending on a number of factors such as changes in care providers or changes in the individual's routine. Internal factors may affect muscle tone which may be difficult to perceive unless the client is well known to the assessors. Internal factors which influence tone include pain, gastroesophageal reflux, constipation, and seizure activity. The effects of medication may also influence muscle tone which is sometimes only apparent over a time.

An extended trial period of four to six weeks allows for input from family and care providers. Problems may develop which were not originally seen, such as pressure points, skin integrity problems, leaning to one side, and sliding out of the chair. Simple problems can usually be corrected by adding or cutting away foam, changing the type of foam in small areas, changing the seat-back angle, or the tilt in space angle.

Title

CREATE A SLIDE PRESENTATION ON YOUR MACINTOSH

Presenters

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Key Words

Computer Technology

Abstract

ClarisWorks is the most integrated software package designed for the Macintosh. This program will suffice for most everything an occupational therapist must do in any setting, clinic, educational or hospital. Since it is integrated all programs within can be shared. Quick access to information about each program is available.

Occupational therapists require a variety of programs in their practice and programs. ClarisWorks provides word processing, a database to maintain an quick ongoing equipment inventory, client list, or employee information, to mention a few. The drawing and painting programs allow colorful presentations about therapy or other aspects unique to therapists. There is a user dictionary available so precise medical terminology can be inserted. ClarisWorks programs are simple to learn, user friendly, and operate simply with HELP assistance available ON SCREEN.

Slide show is special program within ClarisWorks. It allows endless varieties of presentations with interactive use of videos, scanned pictures, drawings & quick time movies, can provide excellent illustration of therapy techniques. The presentations are limited only by the therapists creativity and ingenuity.

Custom text styles, framing, headers, borders & columns are available to lend outstanding creations of slides. The computer monitor becomes the movie screen, the document pages become the slides. There is an automatic time advance which can be set to advance and repeat, order of slides presented & transitioning is available. The cursor can be used as a pointer during each presentation. Once made each presentation can be repeated. Slide Show can be used in many ways:

* A slide presentation to orient client to therapeutic modalities
* A lobby slide presentation to introduce the profession of occupational therapy
* A Kiosk to illustrate specific directions to therapy
* Demonstrations for specific therapy techniques in both academic & clinical settings
* Staff procedural information that must be repeated information can be learned at the individuals' pace, or used as an independent study module
* Statistical tables, as graphs, or graphic charts
* A recruitment presentation specific to your institution is now available.
* Write the presentation in the language most appropriate to your clients.

Although therapy related software is available, quantities are limited, and for diverse populations it is rare indeed. Therapists generally compensate by using related applications. Most therapists are not programmers but do have outstanding creative ideas. Now multicultural software can be created in native languages and then can be shared with others by using the communications program within ClarisWorks Now the versatility of ClarisWorks Slide Show allows individualization within a therapy setting.

The advantage of making a slide presentation is that the therapist is in control of what is being presented. Complexity, language used, time available, & appropriateness, is all under the control of the therapist. The biggest advantage is that the therapist need not be a programmer to used this program.

Pictures are worth thousand of words.

Title

MOUTHSTICKS: A LOW TECH TOOL FOR CHILDREN

Presenters

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Information for this demonstration was obtained during employment as an Occupational Therapy Clinical Specialist at theAlfred I. duPont Institute A Children's Hospital, P.O. Box 269, Wilmington, DE 19899, (302)651-6010.

Key Words

pediatric quadriplegia, mouthsticks, functional activities

Abstract

Children with spinal cord damage of the C1 to C4 region resulting in quadriplegia and ventilator dependency experience decreased opportunities to manipulate their environment and engage in fine motor tasks which alters complex problem solving skill development. Using simple mouthsticks, a variety of developmentally and functionally appropriate cognitive and fine motor tasks are possible.This ultimately results in improved quality of life and enhances the potential for the development of marketable vocational skills. The challenge for the clinician is to identify an activity as it relates to the child's developmental age or skill, and grade it to address the child's perceptual and motor needs.

No documented mouthstick training programs for children were noted in current literature. Lathem, Gregario, and Garber (AJOT 1985) outlined an OT approach for rehabilitating the high level quadriplegia. Painting, page turning, table games, and typing on the computer were the most frequently stated uses of mouthsticks.

Over a period of four years twelve children between the ages of 1 1/2 years and 15 years were seen for their initial rehabilitation of their high level spinal cord injury at the duPont Institute. It was at that time many different tasks were attempted with mouthsticks. For the younger child some of the tasks included; stacking blocks, completingknobbed puzzles, popping bubbles, sounding musical instruments, and pushing hotwheels. For the older

child examples of activities included; games such as UNO & connect four, paper-mache,gardening, painting stain glass and wood projects, and cooking pizza, fruit shakes and cakes. Initially, each child demonstrated fear of not being able to breath on their own and had become depressed from the dramatic changes in their abilities to play, explore their environment, and do the things familiar to them. Learning to direct others to setup a game or an art project and choosing the best mouthstick for the task had notable effects on the patients affect and involvement in directing their own care. Through practice, children had begun to participate in choosing activities they could partake in and telling the therapist how to place a craft item or game piece so they could reach and manipulate it. Normal developmental activities which lead to mature problem solving were possible using assorted mouthsticks.

Mouthstick use also placed a new emphasis on the importance of using ancillary neck and jaw muscles.Working these muscles during play had shown improved head control, less fear in not being able to breath, and better overall endurance for sitting and participating in day to day events.

This presentation will provide hands on opportunity to experience the use of the clamp-on, pointer, and pincer mouthsticks to perform developmental tasks. A picture display of children of various ages engaged in mouthstick play will be on exhibit. As an educational tool, an information packet describing activities and ways to grade them to cater to the individual will be distributed. This packet will also include advice on how to select, obtain, and adapt a prefabricated mouthstick to fit many different sized mouths.

Title

"Newly Developed Telephones For The Severely Disabled Individuals"

Presenters

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Key Words

adapted telephones, assistive technology

Abstract

Communication is essential and pleasurable in daily activity. Telephone communication allows us the ability to interact with others, to care for ourselves at hone, to become employable and to live a higher quality of life.

For persons with disabilities, telephone communication may be a means of safety, communication, work, life tasks, i.e. banking, marketing. Today with the increased use of telecommunication, the employable requirements is becoming a reality for severly disabled persons.

Hands-free and voice activated phones were originally designed for busy executives, however, today they have become the best means of communication for persons with limited upper extremity control or visual impairments. In addition, there are switch activated telephones and computer driven telephones that can maximize the function of

persons with a variety of disabilities. This presentation will demonstrate 4-5 voice activated telephones that have been developed over the past 2 years, that could enhance communication ability of persons with severe disabilities as well as those living alone.

COURSE OBJECTIVES:

Upon completion of this lab experience, the participant will:

1. Cognizant of newly developed telephones that have become available in the past two years.
2. Awareness of how the use of telepones can enhance the function and independence of individuals with severe disabilities.
3. Familiar with the activation of 4 or 5 newly developed telephones.

Title

Program Evaluation Software for Work Hardening

Presenters

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Key Words

Evaluation, Work Hardening

Abstract

This session introduces the newly developed Work and Industrial Rehabilitation Evaluation (WIRE) program. This software was developed in response to the increasing demand by consumers for outcomes studies substantiating work programs' effectiveness. Program evaluation is an essential tool for assessing a program's effectiveness. As defined by the Commission on Accreditation of Rehabilitation Facilities (CARF), program evaluation is the systematic process for determining how effectively and efficiently improvements in a client's functional status are achieved (1). It is the basis upon which to make decisions regarding performance. These decisions involve judgement of quality and standard.

The WIRE program serves as a database for work programs in the collection and analysis of client data for program evaluation. It allows the user to input client data according to 19 different categories:

1. Gender
2. Age
3. Occupational Category
4. Payment Source
5. Referral Source
6. Diagnosis
7. Activities Performed
8. Length of Time Between Date of Injury and Last Day Worked
9. Length of Time Between Last Day Worked and Start of Treatment
10. Length of Time Between Discharge and Actual Return to Work Date
11. Total number of Days attended
12. Average Length of Treatment per Day
13. Length of Treatment-Admission to Discharge
14. Psychological Services
15. Surgery Performed
16. Vocational Services
17. Medical Management
18. Discharge Outcome
19. Total Cost

Data may be collected, stored, retrieved, and analyzed on a quarterly or annual basis. The program has been designed with consideration for CARF accreditation requirements. WIRE software is user-friendly and may be used with IBM PCs and other compatible computers. This program was piloted in 1993 with twenty-two work programs within the state of Wisconsin (2). It demonstrated effectiveness in defining trends, analyzing outcomes, and comparing performance data among programs.

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Title

The IntelliKeys Alternative Computer Keyboard and Software

Presenters

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Key Words

Technology, computers, adaptive equipment

Abstract

The IntelliKeys alternative computer keyboard provides adaptive access to the Apple IIgs, Macintosh, and IBM computers. This expanded keyboard is transparent, allowing use with any software program. A variety of overlays are available for the IntelliKeys and custom overlays may be programmed.

Many Occupational Therapy clients are unable to use a standard keyboard. This may be due to motor, cognitive, or visual impairments. The IntelliKeys may be used for adaptive access to compensate for each of these areas.

Motor: The standard keyboard requires the user to position and sustain arms over the keyboard, accurately touch and depress a key, and reach all necessary keys. The IntelliKeys is an expanded keyboard, allowing larger target areas. Sensitivity can be reduced, allowing the user to slide their hand to the desired target. The IntelliKeys is touch sensitive, so does not require an actual key depression. If range of motion is limited, needed keys can be placed together in a small area of the IntelliKeys.
Cognitive: The standard keyboard requires the user to recognize, discriminate, and select specific characters among 128 keys. The IntelliKeys can be used with overlays that limit choices or arrange them in a manner that makes sense to the user. Pictures or other symbols can be used on the overlay and the keyboard can send the necessary characters to the computer.
Visual: The standard keyboard requires acuity to recognize small characters with little contrast and good perceptual skills to locate a desired character among 128. Overlays on the IntelliKeys can use large characters with any desired contrast. Characters or symbols can even be embossed for tactile feedback.

Standard overlays automatically "load" when slid into place on the IntelliKeys as the keyboard reads a code on the back of the overlay. Parameters, such as sensitivity and mouse control, are all set on a special settings overlay. The IntelliKeys can send any keyboard character to the computer, as well as mouse commands.
Occupational Therapists are uniquely qualified to assess clients for appropriate computer access due to our holistic approach. The IntelliKeys alternative computer keyboard is a valuable resource for Occupational Therapists. The IntelliKeys is very versatile; easy to use, modify, and customize; works with a variety of computers; works with any software program; and is reasonably priced.

The IntelliKeys Keyboard
IntelliTools, Inc.
55 Leveroni Court, Suite 9
Novato, California 94949
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Title The MINIMAL MOTION System: One-Handed Integrated Keyboard/Mouse Access

Presenters
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Key Words COMPUTERS (GENERAL), TECHNOLOGY, SELF-HELP DEVICES

Abstract

This presentation involves a demonstration of the innovative MINIMAL MOTION multi-switch computer access method. This access method accomplishes both keyboard and mouse input just using limited finger flexion. No other hand, wrist, or arm mobility is required. The fingertips of one hand operate conventional or touch-sensitive (zero force) switches, often mounted in a palmer resting splint for proper positioning. For those unable to use the method with one hand, the system can be implemented with other configurations of four or five switches.

This access method is appropriate for a wide variety of users with arm, hand, and finger conditions that limit their range of motion, including some persons with Repetitive Strain Injuries. The demonstration shows that the system is very easy to learn and use, and requires minimal memorization.

Title

Video Interaction Analysis: A Tool for Documenting Assistive Technology Usage

Presenters

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Key Words

Video, multimedia, assistive technology, functional outcomes, documentation

Abstract

A multimedia, portable Video Interaction Analysis system is being used for documenting and analyzing video footage of the assistive technology service delivery process. The system, which integrates commercially available computer and video equipment, is based on a Macintosh portable Powerbook from Apple Computers Inc.

Video footage is taken through a SONY Hi8 camcorder which fits in the palm of the hand and can be easily transported to clinic, home, work and community settings in which the client is using assistive technology. Hi8 cameras with stereo sound are recommended since they offer a higher quality image, especially if dubbing copies.

To replay and analyze the video, the Powerbook is linked to a SONY Walkman which serves as a portable video playback unit. The Walkman has a 3" color monitor and a Hi8 playback deck contained in a small, hand-held unit which can be directly connected to the Powerbook via a L-port connection. Thus the therapist can instantly replay a video clip and show it to the client, family and/or members of the service delivery team for feedback. The unit can also be plugged into a standard TV monitor or an overhead display to show the video to larger groups.

Video footage of clients learning how to use various assistive technologies then can be analyzed using C-Video, a software program that allows the user to control the video player through the computer. The user produces a running log, or transcript, of the video content, including start and stop times for each selected vignette. A vignette refers to a short clip,

usually around 3-5 minutes in length, that highlights an aspect of client performance. This transcript is stored as a computer file which can be edited, printed, and opened at any time. When the user clicks on a vignette selection, the Powerbook sends messages to the video player and the clip is automatically found and played. The system electronically searches for the clip, eliminating the need for the user to rewind or fast forward the tape searching for the clip. The user can also pause, fast forward or rewind the tape via the computer keyboard.

Video Interaction Analysis (VIA), a specific method for group analysis of video footage, was developed at the Institute for Research on Learning (IRL) in Palo Alto, CA [1]. Researchers at IRL used a similar system to analyze the teaching and learning processes employed in mathematics and engineering classes. The method was applied by this author to explore the processes involved in assistive technology (AT) service delivery, including AT assessment, prescription, installation, training, maintenance and modification. Interactions among AT team members, including consumers with disabilities, can be tracked and analyzed for trends and patterns. Video vignettes also can be used to document the effectiveness of AT interventions. Future research in VIA will focus on how to integrate video footage into client reports, equipment orders, and program evaluations. The author is also interested in exploring applications of VIA to the comparative analysis of clinical reasoning among novice and expert clinicians.

References

[1] Roschelle, J., & Goldman, S. (1991). VideoNoter: A productivity tool for video data analysis. *Behavior Research Methods, Instruments and Computers, 23* (2), 219-224.

Title Keystones to Activity and Adventure

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Key Words Innovative activity adaptations

Abstract Items which have been adapted for use in recreation and outdoor activities will be on display for "hands on" demonstration. Fishing, hunting, video games and other activities are made easier and more practical by various adaptations. The complexity of the adaptations ranges from simple to sophisticated technology. Practicality and reliability are emphasized in the implementation of the adaptive devices.

Title

Computer-assisted Instruction: A Portfolio

Presenters

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Key Words

Computer-assisted Instruction
Teaching Methods
Education, Occupational Therapy

Abstract

Computer-assisted Instruction (CAI) is a technique through which the learner is taught by interaction with a computer (Heinrich, Molenda, & Russell, 1989) to achieve specific educational goals. While CAI has been utilized for more than 20 years in health care education (Hmelo, 1989), very few modules have been specifically oriented towards training in occupational therapy (Dengler, 1983). In the current era of increased information access, decreased time availability, the faculty shortage, CAI may be a key resource in addressing many of the issues necessary to make the educational approach more contemporary and future focused.

Two examples of CAI are tutorials and simulations. Tutorials, such as those created for this project, not only give feedback based on student response, but gives students the freedom to set their own learning pace, make mistakes and learn the consequences, and repeat portions as needed; all in a nonthreatening environment. Clinical simulations allow for the standardization of tasks and problems, provide a sampling of a broad range of cases, and give realistic feedback within practical time frames (Hmelo, 1989), at no risk of harm to real-world clientele.

As medical knowledge increases, there is pressure on educational institutions to impart larger bodies of knowledge and application (Hmelo, 1989). Computer-assisted instruction, another method of educating health care professionals, offers several advantages as a teaching tool. It can be used to allow students to: solve open-ended queries; relate theory, clinical reasoning, and treatment selection in an exploratory manner; and finally, by providing practice, gain experience in a variety of problem-solving situations.

Computer-assisted instruction has a role in preparing occupational therapists to adapt to the changing situations that the profession demands, both today and tomorrow. The demonstration of this role will consist of a collection of CAI programs from commercial sources as well as those developed by the authors. A diversity of program topics will be made available including: developmental reflex evaluation, range of motion and manual muscle testing, spinal chord injury education, proper terminology utilization, and testing and evaluation procedures. Attendees will be able to access the tutorials, for a "hands on," interactive experience.

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Hmelo, C.E.(1989). Computer-assisted instruction in health professions education: a review of published literature. Journal of Educational Technology Systems. 18, 83-101.

Title Computerizing Hand Therapy Evaluations

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Key Words

Computers
Hand Therapy
Evaluations

Abstract

As evaluation is an important aspect of hand therapy and computers are widely available within hand therapy clinics, it seems natural to develop computerized evaluation to assist hand therapists in better analyzing and reporting evaluation data. Computerized hand therapy evaluation systems are currently available for thousands of dollars which link evaluation equipment to computers. These systems, however, are beyond the scope of most hand therapy clinic budgets.

The software presented in the Technology Lab allows the practitioner to use a computer to input the results of hand evaluations completed with standard clinic equipment. The advantages to simply recording the results on a chart include the ability for the software to immediately correlate results to the appropriate norms for the age and sex of the patient (by percent) and also to allow the option to make comparisons between two evaluations completed on the same patient.

The comparison of two evaluations includes the representation on a printout of percent increase or decrease in each evaluation category.

Title

Concept Keyboard: Tool for Cooperative Learning

Presenters

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Key Words

technology • occupational therapy services

Abstract

In the 1990s, occupational therapy practitioners working in schools are likely to hear two educational catchphrases: "cooperative learning" and "inclusion." Cooperative learning, the gathering of two or more students into a group, fosters learning by discovery in a more natural environment than the traditional classroom format of the teacher providing all instruction and the children working individually (McNeil, 1994; Slavin, 1991; Schrag, 1993). Replacing the former term, mainstreaming, inclusion represents the latest effort to place children with disabilities into regular classrooms (Beninghof, 1993).

Technology can serve as an equalizing factor to meet challenges facing persons with disabilities (Luebben, 1992). Teachers in regular classrooms and special educators have found that students working together on computers produced increases in behaviors that were positively related with learning (Hine, 1990; Malouf, 1990). Occupational therapy practitioners are in primary positions to use their assistive technology (AT) expertise in making the transition from special education setting to the regular classroom easier.

Additionally, occupational therapists and certified occupational therapy assistants are increasingly finding themselves in AT specialist positions in the public schools (Shuster, 1993). Keeping up with AT requires a commitment to investigate new products (Luebben, 1995).

The Concept Keyboard (CK) is one AT device that not only eases the transition of children out of special educational settings but also facilitates cooperative learning once the students are in standard classrooms. An alternative keyboard, the CK is fully programmable with 256 user defined key areas, each of which can hold up to 128 characters. The CK is a touch sensitive membrane keyboard that is easy to use and cost effective since the device interfaces directly with the computer, saving the purchase of an additional keyboard emulator. At this time, the CK is the only alternative keyboard that can be used in tandem with another CK on a single computer for true cooperative learning. This demonstration allowed participants to have opportunities for hands-on experience with the CK, discuss the features of this keyboard compared with other alternate keyboard features, and receive resource information on the CK.

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Title

Electronic Library: Friendly, Helpful, and Cooperative Databases on Your Desktop

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Key Words

Databases, CD Roms, Libraries

Abstract

The new release of the Co-NET 7 CD continues to be one of those products every therapist should have in their practice. This "user friendly" database library is now composed of 19,000 rehabilitation and assistive devices. In version 7, Co-NET has been further expanded to include the Cooperative Services Directories, a Text Document Library, and a sneak preview of the Publications, Media and Materials database. There isn't another product on the market quite as unique and useful for Occupational Therapists as this CD.

Two versions of ABLEDATA are provided on Co-NET 7: Hyper-ABLEDATA for the MacIntosh and DOS-ABLEDATA for IBM and compatibles. Both are completely accessible to non-sighted individuals. Hyper-ABLEDATA includes a voice output mode for blind users; DOS ABLEDATA is specifically designed to work with commercially available screen readers. Co-NET 7 is additionally a dual boot CD. In plain English, this means that you can run the same CD on both your MacIntosh and IBM computers.

The therapist can continue to explore the ABLEDATA portion of the CD to locate all those allusive rehabilitation and assistive devices that seem to escape both our short- or long-term memory. Brief descriptions, costs, manufacturer's addresses, phone numbers, and an

occasional photograph can be called up on the computer screen for examination by the therapist searching for assistive and rehabilitation devices.

The Cooperative Services Directories continues to provide the therapist with resource directories listing people and agencies that provide disability-related services across the country. One unique feature of the CSD allows the therapist to search for all of the programs that meet the needs of their client, or by themselves, and then have the programs listed in order by their distance from the client's or therapist's location. The directory will also plot the locations of these programs on a map to see how they are distributed throughout your state or region of the country.

The Text Document Library is a collection of complete key-disability documents regarding law, ADA, accessibility, funding, and other topics. These documents are included in their entirety. Whenever possible the documents include text descriptions of any graphics that appeared in the original document.

Co-NET 7 becomes an assistive device, an agency, and a document encyclopedia that every Occupational Therapist should have for use in their practice. Access to accurate and current information is updated every six months on a new CD and can provide even the most isolated therapist with immediate access to the most current equipment, location of centers dealing with disability and recent publications, and laws that have direct impact upon the lives of both the client and therapists.

Co-NET 7th Edition, Trace Research and Development Center, Madison, Wisconsin, 1994.

Title

Environmental Control Systems

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Key Words

Technology; environment, controlled; activities of daily living

Abstract

Environmental control units (ECUs) provide alternative access to battery powered or electronic devices in a person's environment. This may include control of lights, appliances, television, VCR, stereo, telephone, door openers, power to computers and emergency call. ECUs can be used in the home, school or vocational environment. The method of access may be direct (ie. finger to button), switch, voice or through an interfaced device such as a computer or communication device.

Occupational Therapists are uniquely qualified to work with ECUs. ECUs are designed to increase independence and quality of life. For many of our clients, ECUs are the only means of independence in activities of daily living available. Choosing the right ECU involves evaluating motor, cognitive, and sensory skills. The decision must intimately involve the client's needs and goals. The ECU may need to be interfaced with other

technology that the client is using. These are each areas Occupational Therapists specialize in.

A great variety of ECUs are available, although little formal information is available to assist the therapist in determining which system to recommend. Funding is traditionally poor for this area of technology, as well. These two factors often deter Occupational Therapists from being involved in this important area of technology.

Determining a system: Once a method of access has been established as well as devices the client wants to control, cognitive and visual requirements, and interface needs, the choice of ECUs should be narrowed considerably. Many systems have a high cognitive load, requiring good memory and sequencing skills or the ability to read English well. Most systems are visually based, with the exception of voice controlled units and one unit that auditorally scans through menu choices. Other considerations include remote control, battery back-up, product reliability and service, and cost.

Funding: As with other equipment in the past, funding emerges after numerous requests and justifications have been presented repeatedly and often over a long period of time. If a denial is the result, various philanthropic organizations can be very helpful.

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Title

HOW DO THEY DO THAT?

Presenters

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Key Words

Wheelchair and Accessories
Seats, Adapted
Equipment Design

Abstract

OT's rarely have the opportunity to observe or participate in the fabrication of positioning aids, yet they are asked to provide crucial information that influences the fabrication. If clinicians had a better understanding of the materials and fabrication processes, they would be able to provide more information about their clients' needs.

The softness and surface shape (contour) should be considered when selecting a system for an individual. The softness and ability to maintain its shape depend on the firmness, thickness and memory of the material. These factors impact on the postural support and pressure distribution provided to the user. One goal of the positioning aid is to even the pressure distribution so that excessive pressure does not build in any one spot, as this might lead to the development of pressure sores. Pressure distribution over the seating surface can be evened by shaping the seating

surface to match the user's shape. The user's shape can be matched by carving or shaping the surface, or by using soft foam that compresses to match the shape. Compression can actually increase pressure because the foam may push back (called memory) against the user as he presses against it.

Positioning aids should be covered to protect them from punctures and scratches. Because the life of foam is drastically shortened when it is exposed to sunlight and to moisture, the protective coating should seal the foam completely. The covers should be flexible enough so as not to change the shape and softness of the material. Covers should be easy to clean, repair or replace given the user's specific needs. A slick material allows the user to slide for transfers or repositioning and a textured cover offers friction to help hold the user in place.

Adhesives fasten layers of the soft component together and fasten the soft component to the firm. The ability to stick influences the life and maintenance requirements of the system. The "feel" of the adhesive can change the characteristics of the soft component it covers. For example, if the adhesive is stiff, it may add stiffness to the surrounding components, changing the softness of the system.

Hardware is usually plastic or metal (aluminum, stainless steel, etc.). The properties that affect its usefulness include the strength and the likelihood of rusting. Consider whether the hardware is meant to hold the components or allow them to move. Even moveable hardware varies. For instance, some swing away hardware may not swing far enough or may hit another part of the system.

The seating system should be strong enough to meet the user's needs, easy to adjust if that is a priority, and durable to meet the demands of the environment. If the fabricator is provided with information about the user's behavior and usual environments, he can build in additional features. For example, positioning aids can be tethered to the mobility base so that they remain with it even when not in use, knobs can be added so tools are not required to loosen hardware, and additional covers can be supplied if they will become soiled frequently.

Title

Occupational Therapy and the States Tech Act Grant

Presenters

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Key Words

Assistive Technology

Abstract

The purpose of this roundtable is to share experiences regarding the integration of occupational therapy services with the state initiatives involved with the Technology-Related Assistance for Individuals with Disabilities Act of 1988. It is unclear how many occupational therapists are involved with their state's Tech Act grant projects. The development of a mechanism for networking amongst therapists would not only be helpful and supportive, but, could enhance different states' activities and services to consumers.

Title

POWERED MOBILITY: ALTERNATIVE & INTEGRATED CONTROLS

Presenters

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Key Words

Assistive Technology, Power Wheelchair, Integrated Control

Abstract

The advanced electronics now available on power wheelchairs provides users with several options for control of the system beyond the traditional joystick which may be difficult to operate for those with severe physical limitations. The electronics also provide for the integration of controls for other devices through a single control interface. For example, a user has the opportunity to use the joystick controller of the wheelchair to operate the power tilt/recline mechanism of the chair, activate an environmental control unit, emulate the mouse on a computer, or provide scanning input for an augmentative communication device. An integrated control (IC) has significant functional benefit for individuals with only a single reliable motor access site and eliminates the need for multiple distributed controls (DCs).

Typically, the most effective operation of a power wheelchair is through the use of a proportional joystick. The joystick allows for smooth control of speed and directionality. The throw on a joystick operates similar to the accelerator on a car where greater motion of the joystick (or throw) results in increased velocity. The user has the ability to smoothly adjust velocity and maneuverability for given driving

situations directly through joystick movements. The joystick also has the ability to be mounted and adapted for use through several anatomical sites including the hand, foot, elbow, or chin. Unfortunately, effective use of joystick requires a certain degree of fine motor control.

Alternatively, switches are readily available in a multitude of shapes, sizes, and means of access to operate a power wheelchair. To successfully maneuver a power wheelchair, the user needs to access four switches for direction and a fifth selector switch when using ICs. In some cases, a vector scanning interface can be used with individuals who are only capable of accessing a single switch. The disadvantage to switch input, is the lack of smooth driving control experienced with a proportional controller. Driving with switches tends to be "jerky" as an all or none response occurs when a switch is activated.

ICs provide an opportunity for increased function and control with individuals who have severe physical limitations however, certain features of the technology need to be carefully considered by therapists prior to any provision. An IC will only operate a single device at a time therefore, a user would not be able to drive a wheelchair and speak through a communication device simultaneously. Also, the controller is based on the wheelchair thus the user may only control devices while in the wheelchair. This further presents problems should the wheelchair breakdown. The use of an IC also requires a certain level of cognitive ability in order to comprehend the relationship between a single controller and multiple functions.

With advances in technology, several alternatives exist to operate and control assistive devices however, provision of the most appropriate intervention can only be assured through a thorough team evaluation of an individual's needs and full knowledge of the applications and limitations of the technology. Currently, empirical research is being conducted at Rancho Los Amigos Medical Center and at the University of Pittsburgh to clarify the appropriate application of integrated controls.

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Manufacturers of Alternative & Integrated Controls

Adaptive Switch Lab - 1181 Baltimore Rd., Suite 500, Houston, TX 77043 (800) 626-8698
DU-IT Control Systems Group, Inc. - 8765 Twp. Rd. 513, Shreve, OH 44676 (216) 567-2906
Everest & Jennings - 1100 Corporate Square Drive, St. Louis, MO 63132 (800) 788-3633
Fortress Scientific - P.O. Box 489, Clovis, CA 93613 (800) 866-4335
Invacare - 899 Cleveland St., Elyria, OH 44036 (800) 333-6900
Permobil - 6B Gill St., Woburn, MA 01801 (617) 932-9009
Quickie-Dufco - 2842 Business Park Ave., Fresno, CA 93727 (800) 456-8165
TASH - Unit 1-91 Station St., Ajax, ON L1S 3H2 (905) 686-4129

Title

A Rocky Mountain High - Adaptive Skiing in the Rockies!

Presenters

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Key Words

Equipment Design, Handicapped, Leisure Activities

Abstract

Those who visit this "hands on" exhibit at the Assistive Technology Lab at the Denver AOTA Conference, April 10, 1994 will understand that Adaptive Skiing:

- supports inclusion in family and community recreation, adds or restores excitement to daily living, increases personal and physical confidence and supports the development of new relationships for persons with disabilities.
- is possible for most any motivated person with a physical, cognitive or sensory disability to learn an adaptive ski method. Individuals with learning disability, blindness, paraplegia, stroke, Spina Bifida, head injury, amputations, Multiple Sclerosis, and even quadriplegia are now successful skiers.

- is offered by certified instructors at many adaptive ski programs across the United States and Canada.
- has specialized equipment chosen or customized to maximize an individual's residual abilities and that equipment can be borrowed, rented or purchased from a variety of resources across the country.
- has specialized instruction methods that are intended to lead a skier with a disability through a skill progression while making the learning an adaptive ski method safe and fun.

Attendees will be able to:

- try out adaptive ski equipment including a monoski, a bi-ski, ski-eze, walker on skis, outriggers for 3 tracking and a ski bra.
- get a list of adaptive ski instruction programs
- get a list of adaptive ski equipment manufacturers
- see a video of adaptive ski methods
- see a slide show of adaptive skiers, methods, and events

Instructors in Adaptive Skiing are certified as possessing one of 3 levels of skill in one or more adaptive ski methods through a cooperative arrangement between two ski organizations: National Handicapped Sports and Professional Ski Instructors of America. Adaptive certification is given in the following adaptive methods: blind, three track, four track, mono-ski, bi-ski, and developmental disabilities.

For more information about adaptive skiing programs and resources in your area contact:

National Handicapped Sports @ 301/217-0960 (for the name of one of more than 80 local NHS chapters or for the name of an adaptive ski program near you)

Or contact the presenters named above who are PSIA certified adaptive instructors.

Title

Scanning Assessment Tool

Presenters

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Key Words

scanning assessment, computerized evaluation tool, switch assessment

Abstract

Assistive technology has opened doors for individuals with disabilities. It provides greater access to written and spoken communication and mobility. Greater access provides greater educational and vocational opportunities. Technology assists individuals execute tasks that prior to having assistive devices they could not perform.

Some areas of assistive technology have received concentrated efforts of study to influence improvement. Still other areas essential in developing optimal access methods for assistive devices remain largely unstudied. Scanning falls into the latter group. Scanning is the interface method of pressing a switch with one body part to command a cursor on a communication device, computer, or environmental control unit.

There are three areas of concern regarding scanning. First, users are not adequately assessed for the specific scanning mode most appropriate for them. Automatic scanning is the mode most often used. Preliminary findings show that youths with cerebral palsy performed most poorly using this mode. Thus, persons who use scanning may be using the method that is least effective. Second, the cursor speed must be slow enough for the user to control the scan mode adequately. Using an inappropriate mode necessitates decreasing cursor speed to allow for accuracy. When clients uses the appropriate scanning mode, the speed can be increased. Users are more efficient and faster using the proper mode. Third, no assessment tools are

available to assist clinicians in assessing this critical area in assistive technology assessment. This paper addresses the last concern, how assess for scanning.

A software program has been developed to assess scanning; the Scanning Assessment Tool. This tool provides measurable information for the three scanning modes; automatic, inverse, and step. The Scanning Assessment Tool software program provides the following evaluation options:

- Auto, Inverse and Step scanning modes testing
- number of boxes (three, six, or nine) to be scanned horizontally
- the time the cursor begins to move, and
- cursor speed during scanning.

The program collects information on: I) scanning mode, 2) cursor speed, 3) switch used, and 4) switch position. Printouts of the information collected are available in either graph or table form. This information can be presented to client, parents, teachers, physicians, and other clinicians. This information can help explain why a particular scanning mode was chosen. With measurable information, clinicians are better equipped to recommend the most appropriate scanning mode and cursor speed.

Preliminary results using this tool with youths with cerebral palsy indicate that each mode should be evaluated separately. Put in functional terms, with the current results, therapists cannot predict how a client may perform using the different modes. The client should be allowed to use each mode for a period of time. The scores reviewed by the client and therapist together deciding which mode will be best for the client to use.

This programs runs on a Macintosh computer with hard disk, System 7 or higher, high density disk drive, and Hyper Card 2.1 or higher. Program size is 200k. To operate it using a switch, a Ke:nx or Macintosh Switch Interface is needed, both available from Don Johnston Developmental Equipment.

Title

Technology as a Tool for Interactive Learning

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Key Words

Technology
School-based Occupational Therapy

Abstract

With the movement toward the inclusion of all children into our public schools, occupational therapists are required to create and implement activities which challenge the skills of children with a wide range of abilities. Assistive technology and its many applications has become a tool widely used to provide support to children of varying abilities. Educational software paired with computers can be used by occupational therapists to promote play, learning, cooperation, and socialization in typical classroom environments. Assistive technology, creatively used, enables children with varying abilities to be included in educational activities with their typical peers.

The Macintosh computer, with specialized software will be used in conjunction with alternate input devices to demonstrate an interactive activity. The activity will demonstrate the utility of assistive technology in bridging the gaps between children with differing needs. The activity is designed around Millie's Math House, a software program by Edmark. Millie's Math House is designed to teach beginning mathematical concepts including number, shape, and pattern recognition and basic counting skills all within a program that encourages creativity and exploration. Alternate access methods are used which have been custom designed to meet the needs of the child with motoric involvement. ClickIt! and Overlay Maker both by IntelliTools,

are software programs that were used to adapt Millie's Math House and customize access to the computer. ClickIt! enables the adaptation of any mouse driven Macintosh program to allow access without the use of a mouse. Overlay Maker is designed to make custom overlays for the IntelliKeys keyboard, an alternate keyboard useful for computer users with motoric, visual and/or cognitive impairments.

Computers are becoming more and more present in our everyday lives. With simple adaptations, the computer becomes a powerful tool to help level the playing field when children with differing abilities come together in the educational setting. Occupational therapists will be increasingly called upon to provide information surrounding issues of access for children with disabilities within their school environments.

Title

The Use of a Computerized Database for Fieldwork

Presenters

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Key Words

fieldwork, computerization, information management

Abstract

The amount of information which is collected and utilized in the fieldwork process is great. Fieldwork coordinators, fieldwork site supervisors, and students require access to current information in a timely manner. We are demonstrating a fieldwork database which is accessible to all clinicians, students and educators via the Internet.

Unidata is a database product that we used to create the database in a manner which allows access regardless of computer operating system. At Duquesne we can utilize Unidata's extensive query language *Uniquery* to create custom reports from the information contained in the database.

Gopher is an Internet-based information retrieval system. Gopher allows us to make our site information available to the Internet community at large. This provides the opportunity for educational institutions across the state to simultaneously gain access to all current information on fieldwork sites. Fieldwork sites will also benefit as they now need only furnish information to a single institution, to reach all institutions.

In the current system, site data entry and maintenance are handled through text based screens built using a product called Envision. This text based product is capable of properly handling many different types of terminals utilizing serial, dial-up, or hardwired network connections. As information is entered or modified in the site database, a post-processing program, written by Duquesne, creates a multi-page document for the site and deposits this file in an intermediate location. A second post-processing routine then picks up these documents from this holding location and, based upon information about the site contained in the document, places them in the correct locations within the Duquesne Gopher.

The information in gopher is organized in such a way as to allow the students to do rudimentary searching to narrow the field of sites they choose to review. Each document in the Gopher system is categorized by its Health Science program(OT,PA,PT,AT,IS,PF), the type of facility and the city/state within which it is located. By making menu choices that relate to their interests and program requirements, students can quickly locate the potential sites and review the information.

As of July this system has been implemented and is being utilized at Duquesne University. A master listing of fieldwork data forms is being reviewed and updated by the educational institutions in the state of Pennsylvania. Upon receipt of the completed fieldwork data forms, information in the Health Sciences Fieldwork Database is being updated and expanded.

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